



## INFORMED CONSENT FOR OUTPATIENT SERVICES

Welcome to Serenity in Motion. This document contains important information about our professional services and business policies. Please read it carefully. Do not hesitate to contact us if you have any questions regarding any of the services or policies. Signing this Informed Consent Form represents your understanding of, and agreement to, the services and policies of Serenity in Motion.

### COUNSELING SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems the client hopes to address. There are many different methods our therapists at Serenity in Motion may use to deal with those problems.

Psychotherapy is a very active process. In order for the therapy to be most successful, the client will have to work on things discussed in session and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of a client's life, they may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees as to what you will experience. Our therapists work diligently to ensure they provide the greatest opportunity for growth and healing with their clients.

The first few sessions between a client and therapist primarily involves getting to know one another, identifying the presenting problem, and evaluating client needs. This allows both the client and therapist to determine if they feel comfortable working with one another, and for the therapist and client to develop a treatment plan to follow. This treatment plan will help the client achieve his or her goals. If the client or therapist feel the working relationship is not ideal, the therapist will make every effort to refer the client to a therapist who is more suited to the client's needs and better able to help.

Therapy involves a large commitment of time, money, and energy, so every client should put care into choosing a therapist. Serenity in Motion has many caring and compassionate therapists with diverse backgrounds who work hard to help each person reach their highest potential. If you have questions about Serenity in Motion procedures, discuss them whenever they arise. If your doubts persist, those of us at Serenity in Motion will be happy to help you set up a meeting with another mental health professional for a second opinion.

### MEETINGS

Individual, couples, and family sessions typically are 55 minutes in length. Traditionally, clients are seen once per week, however this frequency may increase or decrease depending on client needs.

### PROFESSIONAL FEES

Serenity in Motion charges an hourly fee of \$150 for individual, couples, and family therapy and \$70 per hour for group therapy. In addition to therapy, Serenity in Motion charges \$150 per hour for other professional services, such as psychological evaluation report writing, telephone conversations, attendance at meetings with other professionals you have authorized, preparation of treatment



# Serenity in Motion

Counseling Services

summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for any professional time we spend on your legal matter, even if the request comes from another party.

## **BILLING AND PAYMENTS**

Clients are expected to pay for each session at the time of service. Payment schedules for other professional services will be agreed to when such services are requested.

## **INSURANCE REIMBURSEMENT**

In order for Serenity in Motion to set realistic treatment goals and priorities, it is important to evaluate what resources our clients have available to pay for their treatment. If clients have a health insurance policy, it will usually provide some coverage for mental health treatment. We at Serenity in Motion will fill out forms and provide clients with whatever assistance they are able to help ensure clients the benefits to which they are entitled; however, the client (not their insurance company) is responsible for full payment of Serenity in Motion fees. It is very important that each client find out exactly what mental health services their insurance policy covers.

Clients are strongly encouraged to carefully read the section in their insurance coverage booklet that describes mental health services. If there are any questions about the coverage, clients are asked to call their plan administrator. Serenity in Motion will provide clients with whatever information we can based on our experience and will be happy to help clients in understanding the information they receive from their insurance companies.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end.

All clients should also be aware that most insurance companies require that Serenity in Motion provide them with their clinical diagnoses. Sometimes, we are asked to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, Serenity in Motion has no control over what the insurance companies do with that information once they are in possession of it. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any records we submit, if you request it. ***Please understand that, by using your insurance, you authorize us to release such information to your insurance company. We will try to keep that information limited to the minimum necessary.***

Once Serenity in Motion has the client's insurance coverage information, a discussion between therapist and client can be held to review what the client can expect to accomplish with the benefits that are available, and what will happen if they run out before the client feels ready to terminate services.



# Serenity in Motion

Counseling Services

Clients always have the right to pay for services themselves to avoid the problems described above (unless prohibited by the insurance contract).

**\* When services are covered by Medicaid and another source, any payment the member receives from the other source must be turned over to Medicaid. \***

## CONTACTING THERAPISTS

Individual therapists are often not immediately available by telephone. Though they are usually in the office, they will usually not answer the phone when they are with a client. Most phone calls will be answered by Serenity in Motion's office manager during business hours, or by voicemail. All voicemails will be responded to in a timely manner. A representative of Serenity in Motion will make every effort to return a call on the same day it was made, with the exception of weekends, holidays, and after-hour calls. If a client is difficult to reach, additional information on when they are available for a return call is appreciated. If you are in crisis and/or immediate need, please call 911.

## ELECTRONIC COMMUNICATION POLICY

### Email Communications

Serenity in Motion holds client confidentiality as a top priority and uses email communication and text messaging only with client permission and only for administrative purposes. That means that email exchanges and text messages should be limited to things like setting and changing appointments, billing matters, and other related issues. ***Please do not email about clinical matters because email is not a secure form of communication.*** If a client needs to discuss a clinical matter, they are encouraged to do so over the phone or in their next therapy session. Telephone or face-to-face communication is much more secure as a mode of communication.

### Text Messaging

Personal cell phone contact between client and therapist is not encouraged by Serenity in Motion.

### Social Media

Therapists at Serenity in Motion do not communicate with, or contact, any clients through social media platforms, such as Twitter and Facebook. In addition, if therapists at Serenity in Motion discover they have accidentally established an online relationship with a client, they will cancel that relationship immediately. This is because these types of casual social contacts can create significant security risks for clients.

It is our position at Serenity in Motion that any communication with clients online has a high potential to compromise the professional relationship. As such, we ask that clients not attempt to contact therapists in this way.



# Serenity in Motion

Counseling Services

---

## **Websites**

Serenity in Motion has a website that clients are encouraged to access. If clients have any questions, they are encouraged to discuss them at their next therapy session.

## **Web Searches**

Serenity in Motions does not use web searches to gather information about clients without their permission. We believe that this is a violation of client privacy rights.

## **CONFIDENTIALITY (for adult clients [individual counseling])**

In general, the privacy of all communications between client and therapist is protected by law, and information can only be released with written permission from the client. However, there are a few exceptions to this rule.

- In some limited situations (such as a court order) the law allows or requires us to use or disclose your confidential information without your permission.
- If there is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect.
- If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit.
- If you introduce your emotional condition into a legal proceeding.

## **CONFIDENTIALITY (for adult clients [couples/family counseling])**

When working with couples/families in counseling, our therapists view the client as the couple/family unit. As such, our therapists work to create avenues of open communication and are not keepers of secrets. What one member of a couple/family discloses becomes open for discussion with the other intimate partner. Our therapists will help you feel comfortable sharing your disclosure in a safe and supportive environment. However, we maintain fully open and honest communication with our clients to help promote growth and healing.

## **CONFIDENTIALITY (for all clients)**

Serenity in Motion therapists may occasionally find it helpful to consult other professionals about a case. During a consultation, therapists make every effort to avoid revealing the identity of their clients. The consultant is also legally bound to keep the information confidential.

Ordinarily, Serenity in Motion will not tell clients about these consultations unless it is believed that it is important to the client/therapist work.

Although this written summary of exceptions to confidentiality is intended to inform clients about potential issues that could arise, it is important that clients discuss any questions or concerns they may have with their therapist at their next meeting. Our therapists will be happy to discuss any issues with clients and provide clarification when possible.



# *Serenity in Motion*

Counseling Services

---

Your signature below indicates that you have read the information in this document and agree to abide by its terms during the professional relationship between you and Serenity in Motion, and its representatives.

CLIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



## **MINORS:**

### Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify Serenity in Motion immediately. We will ask you to provide a copy of the most recent custody decree that establishes the custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is our policy to notify the other parent that we are meeting with your child. We believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, we will strive to listen carefully so that we can understand the parents' perspectives and fully explain our perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, we will honor that decision, unless there are extraordinary circumstances. However, in most cases, we will ask that you allow us the option of having a few closing sessions with your child to appropriately end the treatment relationship.

### Individual Parent/Guardian Communications with Our Therapists

In the course of treatment for your child, a therapist from Serenity in Motion may meet with the child's parents/guardians either separately or together. Please be aware, however, that at all times, the client is your child – not the parents/guardians, nor any siblings or other family members of the child.

If one of our therapists meet with you or other family members in the course of your child's treatment, the therapist will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

### Mandatory Disclosures of Treatment Information

In some situations, Serenity in Motion and their therapists are required by law or by the guidelines of our profession to disclose information, whether or not we have your or your child's permission. Here are some examples.

Confidentiality cannot be maintained when:

- Child clients state they plan to cause serious harm or death to themselves, and there is belief they have the intent and ability to carry out this threat in the very near future. We must take steps to inform a parent, guardian, or others of what the child has disclosed, how serious this threat is, and try to prevent the occurrence of such harm.
- Child clients disclose they plan to cause serious harm or death to someone else, and there is belief that they have the intent and ability to carry out this threat in the very near future. In this



situation, we must inform a parent, guardian, or others, and may be required to and may be required to inform the person who is the target of the threatened harm, and the police.

- Child clients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, we will need to use professional judgment to decide whether a parent or guardian should be informed.
- Child clients disclose, or the therapist otherwise learns that, it appears that a child is being neglected or abused physically, sexually, or emotionally, or that it appears that they have been neglected or abused in the past. In this situation, the therapist is required by law to report the alleged abuse to the appropriate state child protective agency.
- If Serenity in Motion is ordered by a court to disclose information.

### Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy," where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is Serenity in Motion's policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed without your child's agreement. This includes activities and behaviors that you may not approve of (or might be upset by), but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then the therapist will use his or her professional judgment to decide whether your child is in serious and immediate danger of harm. If the therapist feels that your child is in such danger, he or she will communicate this information to you.

**Example:** If your child discloses that he/she has tried alcohol at a few parties, the information would remain confidential. If your child discloses that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, this information would not remain confidential from you. If your child discloses, or if there is reason to believe, that your child is addicted to drugs or alcohol, that information would not remain confidential.

**Example:** If your child discloses that he/she is having voluntary, protected sex with a peer, that information would remain confidential. If your child discloses that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, that information would not remain confidential.

You can always ask questions about the types of information your child's therapist would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing \_\_\_\_\_, would you tell the parents?"

Even when there is consensus about what information about your child's treatment is kept confidential, there may be information important for you to know about a particular situation that is going on in your child's life. In these situations, the therapist will encourage your child to tell you, and the therapist will help your child find the best way to do so. Also, when meeting with you, the therapist may sometimes



# Serenity in Motion

Counseling Services

describe your child’s problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

### Disclosure of Minor’s Treatment Records to Parents

Although the laws of Montana may give parents the right to see any written records kept about your child’s treatment, by signing this agreement, you are agreeing that your child or teen should have a “zone of privacy” in their meetings with their therapist.

### Parent/Guardian Agreement Not to Use Minor’s Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although our responsibility to your child may require us helping to address conflicts between your child and you, the therapist’s role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena records from Serenity in Motion, or ask the therapist to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing an opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring testimony, even though our therapists will not do so unless legally compelled. If our therapists are required to testify, they are ethically bound not to give an opinion about either parent’s custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, we will provide information as needed, if appropriate releases are signed, or a court order is provided, but our therapists will not make any recommendation about the final decision(s). Furthermore, if a therapist from Serenity in Motion is required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for our participation agrees to reimburse Serenity in Motion, or their representative, at the rate of \$150 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

### Child/Adolescent Patient:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask us at any time.

Minor’s Signature\* \_\_\_\_\_ Date \_\_\_\_\_

*\* For very young children, the child’s signature is not necessary\**

### Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child’s privacy:

- I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. \_\_\_\_\_
- Although I may have the legal right to request written records/session notes because my child is a minor, I agree to granting my child a zone of privacy which allows the child a degree of confidentiality. \_\_\_\_\_





# Serenity in Motion

Counseling Services

---

- I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above. \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_





# Serenity in Motion

Counseling Services

## Client Financial Agreement:

First Name	Middle Name	Last Name		
SS#	DOB	Gender		
Physical Address	City	State	Zip Code	
Mailing Address	City	State	Zip Code	
Employer Name	Employer Address	Occupation		
Home Phone	Work Phone	Cell Phone		
Email Address	Emergency Contact Name	Emergency Contact Number		

In agreement with the services that will be provided by Serenity in Motion, I hereby agree and authorize my insurance company to pay this practice in full for services rendered in accordance with my medical benefits, as agreed to in my insurance policy. I hereby authorize Serenity in Motion to release to my insurance company any information necessary for seeking reimbursement for the services listed below.

### **FEE SCHEDULE:**

Initial Therapy Evaluation (60 minutes)	\$200
Chemical Dependency Evaluation (60 minutes)	\$200
Individual, Couples, Family Therapy Session (55 minutes)	\$150
Group Therapy Session (60-90 minutes)	\$70-\$105
Court Appearance Retainer (minimum 3 hours)	\$450
Court Appearance Fee/Depositions per hour	\$150
Phone Consultation, Report Writing, Professional Fees per hour	\$150

### **CO-PAYMENTS:**

All applicable co-payments, deductibles, or any other out-of-pocket expenses are expected to be paid at the time of the appointment. The co-payment/co-insurance/deductible is your responsibility and payments are expected at the time of your appointment unless your insurance coverage requires another arrangement. Payment is accepted by cash, check, credit card, or debit card. A \$50 fee will be charged for checks returned due to insufficient funds, which is due at the time of the next session. Serenity in Motion reserves the right to increase fees in the future to a reasonable amount, and you will be given adequate advanced notice if this should occur.

My insurance provider is \_\_\_\_\_.  
 My co-payment (as assigned by my insurance company) is \$ \_\_\_\_\_.  
 My insurance entitles me to \_\_\_\_\_ therapy sessions per year, of which I have used \_\_\_\_\_.



# Serenity in Motion

Counseling Services

## **MISSED APPOINTMENTS:**

I understand that it is my responsibility to schedule and ensure that these appointments are kept. I understand that if I am unable to attend my scheduled appointment that I must call, cancel, or reschedule my appointment at least 24 hours before the appointment.

## **COLLECTIONS:**

Bills that are over 90 days overdue may be forwarded for collections. Insurance claims not paid within 90 days may be billed to you. You are responsible for any fees incurred by Serenity in Motion during the attempt to collect overdue payments, including attorney fees.

## **INSURANCE PROCESSING:**

Your insurance company may require that you pre-authorize your treatment with us prior to your visit. It is your responsibility to monitor insurance benefits, co-payments, deductibles, as well as effective and termination dates of coverage. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have any questions, please contact your plan administrator. Feel free to speak with your provider if assistance is needed with this.

Our financial agreement with you is one aspect of our therapeutic relationship. You have our commitment to your healing and well-being, and this includes our willingness to form a financial contract with you that will be mutually agreeable. By signing below, you affirm that you have read, understand, and agree to the finance agreement as outlined above.

I authorize my insurance company to make payments directly to Serenity in Motion for services rendered.

---

Client Printed Name (or parent/guardian if client under age 18) mm/dd/yyyy

---

Client Signature (or parent/guardian if client under age 18) mm/dd/yyyy

---

Serenity in Motion, LLC Representative Signature mm/dd/yyyy



## Client Questionnaire:

Please fill in the information below and bring it with you to your first session. Please note information provided on this form is protected as confidential and personal information.

### **Personal Information:**

Client Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Legal Guardian (if under 18): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Street City State Zip

Street City State Zip

Home Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_ May we leave a message? Yes No

Cell Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_ May we leave a message? Yes No

May we text? Yes No

Email: \_\_\_\_\_ May we email? Yes No

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ Race: \_\_\_\_

Religion/Spiritual Alliance: \_\_\_\_\_

Marital Status:  SINGLE  INTIMATE PARTNER  DOMESTIC PARTNERSHIP  MARRIED

SEPARATED  DIVORCED  WIDOWED

Referred By (if any): \_\_\_\_\_



# Serenity in Motion

Counseling Services

## **Presenting Problem(s):**

Presenting Problem(s) (what is causing you distress?): \_\_\_\_\_

\_\_\_\_\_

Symptoms (how do you know when you are in distress?): \_\_\_\_\_

\_\_\_\_\_

Onset (when did your symptoms begin?): \_\_\_\_\_

\_\_\_\_\_

Duration (how long do your symptoms last?): \_\_\_\_\_

\_\_\_\_\_

Frequency (how often are symptoms present): \_\_\_\_\_

\_\_\_\_\_

## **Psychiatric History:**

Psychiatric Care Provider (DO, MD, NP, PA):

Who: \_\_\_\_\_

Where: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Prior Out-Patient Treatment:

Who: \_\_\_\_\_

Where: \_\_\_\_\_

When: \_\_\_\_\_

What symptoms: \_\_\_\_\_

What diagnoses: \_\_\_\_\_

Prior In-Patient History:

What in-patient institution(s): \_\_\_\_\_

Where: \_\_\_\_\_

When: \_\_\_\_\_

What symptoms: \_\_\_\_\_

What diagnoses: \_\_\_\_\_

Self-Harming Behaviors:

Method: \_\_\_\_\_

Where: \_\_\_\_\_



# Serenity in Motion

Counseling Services

First/Last incident: \_\_\_\_\_  
Contributing factors: \_\_\_\_\_  
Suicide Attempts:  
Method: \_\_\_\_\_  
When: \_\_\_\_\_  
Contributing factors: \_\_\_\_\_

## **Trauma History:**

Nature of trauma: \_\_\_\_\_  
When occurred: \_\_\_\_\_  
Persons involved: \_\_\_\_\_

## **Family Psychiatric History:**

History of mental illness in the family:  
Who: \_\_\_\_\_  
Diagnoses: \_\_\_\_\_  
In/Out-Patient Services: \_\_\_\_\_

## **Medical Conditions & History:**

Primary Care Provider (DO, MD, NP, PA):  
Who: \_\_\_\_\_  
Where: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

Current Medical Conditions: \_\_\_\_\_  
Treatments: \_\_\_\_\_

Past Medical Conditions: \_\_\_\_\_  
Treatments: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Allergies: \_\_\_\_\_

## **Current Medications:**

Medication(s): \_\_\_\_\_  
Dosage(s): \_\_\_\_\_  
Purpose: \_\_\_\_\_  
Prescriber: \_\_\_\_\_



# Serenity in Motion

Counseling Services

## Substance Use History:

Type of Substance	Age of first use	Age of last use	Amount	Frequency	Method of use	Treatment
<input type="checkbox"/> Alcohol						
<input type="checkbox"/> Amphetamines						
<input type="checkbox"/> Benzodiazepines						
<input type="checkbox"/> Cannabis/Hash						
<input type="checkbox"/> Cocaine/Crack						
<input type="checkbox"/> Ecstasy/Molly						
<input type="checkbox"/> Hallucinogens						
<input type="checkbox"/> Hashish						
<input type="checkbox"/> Heroin						
<input type="checkbox"/> Inhalants						
<input type="checkbox"/> Methadone						
<input type="checkbox"/> Methamphetamine						
<input type="checkbox"/> Opiates						
<input type="checkbox"/> PCP						
<input type="checkbox"/> Suboxone						
<input type="checkbox"/> Synthetic drugs (spice, bath salts, salvia, etc.)						

## Family History:

Family of origin:

Father: \_\_\_\_\_ Present during childhood?    Yes    No

Mother: \_\_\_\_\_ Present during childhood?    Yes    No

Brother(s): \_\_\_\_\_ Present during childhood?    Yes    No

Specify #: \_\_\_\_\_

Sister(s): \_\_\_\_\_ Present during childhood?    Yes    No

Specify #: \_\_\_\_\_

Relationship to family of origin: \_\_\_\_\_

Current family:

Spouse (Name, Age): \_\_\_\_\_

Children (Name(s), Age(s)): \_\_\_\_\_

Quality of relationship to family: \_\_\_\_\_

## Social History:

Significant relationships: \_\_\_\_\_

Social supports: \_\_\_\_\_

Nature/Quality of relationships: \_\_\_\_\_



# Serenity in Motion

Counseling Services

## **Developmental History:**

Developmental delays: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Educational/Occupational History:**

Highest grade completed: \_\_\_\_\_  
Current employer: \_\_\_\_\_  
Position: \_\_\_\_\_

## **Legal History:**

Number & Location of Arrests: \_\_\_\_\_  
\_\_\_\_\_  
What charges: \_\_\_\_\_  
\_\_\_\_\_

Number & Location of Incarcerations: \_\_\_\_\_  
\_\_\_\_\_  
What charges: \_\_\_\_\_  
\_\_\_\_\_

## **Strengths/Limitations:**

Strengths List: \_\_\_\_\_  
\_\_\_\_\_  
Limitations List: \_\_\_\_\_  
\_\_\_\_\_

## **Other important information:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I attest that the information provided in or attached to this questionnaire is complete, accurate, and true to the best of my knowledge.

\_\_\_\_\_  
Client Signature mm/dd/yyyy

\_\_\_\_\_  
Parent/Legal Guardian Signature (if client is a minor) mm/dd/yyyy

\_\_\_\_\_  
Serenity in Motion, LLC Representative mm/dd/yyyy