Discover·Explore·Empower

Client Intake Form-Adult

Welcome to Thrive Counseling!

Please provide information to assist your initial session with your therapist.

Name:_____ DOB: _____Date:_____

Reason for seeking therapy:

Symptoms:_____

_____

_____

_____

Current Medications and dosage: _____

_____

_____

Current Providers: (Therapist, Psychiatrist, County Worker, Adoption worker, Medical doctor, etc):

_____

_____

_____

_____

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Referral source:

□ Internet/Social Media □Provider_____
□Other:_____

Mental Health History

Hospitalizations (ONLY for Mental Health):

Hospital: Dates:

_____ _____

_____ _____

Day Treatment:

_____ _____

Previous Providers (Therapists, Psychiatrists, County workers, Adoption workers):

_____ _____

_____ _____

_____ _____

Previous/current assessments (Psychological/neuropsych assessments, IEPs, etc.):

_____ _____

_____ _____

Living Situation

Primary Household-Current

Name	Relationship	Age	Occupation/School	Highest level education	Quality of relationship

Primary Household-Childhood/Teen years:

_____

_____

_____

Developmental History

Pregnancy-Your mom:	**Yes**	**No**	**Unknown**
had to take medications: Specify:			
Took illicit drugs			
Drank Alcohol			
Experienced abuse			
Other			
Your delivery-birth Complications? Specify:			

Met Developmental Milestones on time? (If not which one were delayed)

_____

Childhood/Adolescent Health-Did you:	**Yes**	**No**	**Unknown**
Have Serious Accidents (car, head, bike):			
Hospitalizations (medical only):			
Major Illness:			

Adult Health Issues-Did you:	**Yes**	**No**	**Unknown**
Have Serious Accidents: (car, head, bike):			
Hospitalizations (medical only):			
Illness:			

Education:

Did you receive special education services? □Yes □No

Individualized Education Plan? □Yes □No

504 Plan? □Yes □No

Trauma History

Have you experienced the following:

□Physical Abuse □Verbal Abuse □Sexual Abuse □Neglect

□Subjected to Domestic Violence/Abuse □Witnessed Domestic Violence

□Separated from birth parent (How many times_____ ages_____)

□Experienced Termination of Parental Rights (age/date):_____

□Adoption (age/date):_____

□Disrupted Adoption: (age/date): _____

□Other Significant Loss: (describe):_____

Family Mental Health (diagnoses, symptoms, chemical use):

Mother/Mother's side:_____

Father/Father's side:_____

Family Medical Health (Heart disease, diabetes, etc.):

Mother/Mother's side:_____

Father/Father's side:_____

Tobacco, Drug and Alcohol Use

CAGE:

1. Have you ever felt you ought to cut down on your drinking or drug use? □Yes □No
2. Have people annoyed you by criticizing your drinking or drug use? □Yes □No
3. Have you felt bad or guilty about your drinking or drug use? □Yes □No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? □Yes □No

Do you want additional information or help with chemical use? □Yes □No

Support System:

_____
_____
_____
_____

Strengths/Hobbies:

_____
_____
_____
_____

Challenges/Things to work on:

_____
_____
_____

What is your end goal of your therapy/what would you like things to look like for self/family:

_____
_____
_____

_____