THRIVE LIFE
COUNSELING & WELLNESS

INTAKE FORM

Please provide the following information and answer the questions below prior to your first session. Information you provide here is protected as confidential information. A minimum of 24-hour notice is required for all cancellations. No shows and same day cancellations are not covered by insurance/EAP/MOS.

Name _____ **Birth Date** _____/_____/_____
(Last) (First) (Middle initial)

Address _____ **Phone** _____

_____ **May we leave message?** _____ _____
Yes No

Email _____

Name of parent/guardian/sponsor

_____ **Sponsor Birth Date** _____/_____/_____
(Last) (First) (Middle initial) **SSN# (for billing)** _____/_____/_____

Address _____ **Phone** _____

_____ **May we leave message?** _____ _____
Yes No

Email _____

Please list any children/age _____

_____

Status

___Never Married ___Domestic Partnership ___Married ___Student

___Separated ___Divorced ___Widowed ___ Retired

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Referred by _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc)?

_____ No

_____ Yes _____

Are you currently taking any prescription medication?

_____ _____

_____ _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? Please list any specific health problems you are currently experiencing
   ___Poor ___Unsatisfactory ___Satisfactory ___Good ___Very Good

   _____

   _____

2. How would you rate your current sleeping habits?
   ___Poor ___Unsatisfactory ___Satisfactory ___Good ___Very Good

3. How many times per week do you generally exercise? _____

4. Please list any difficulties you experience with your appetite or eating patterns

   _____

   _____

5. Are you currently experiencing overwhelming sadness, grief or depression?
   _____ No
   _____ Yes _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
   _____ No
   _____ Yes _____

7. Are you currently experiencing any chronic pain?
   _____ No
   _____ Yes _____

8. Do you drink alcohol more than once a week? _____ Yes _____ No

9. How often do you engage recreational drug use?
   ___Daily ___Weekly ___Monthly ___Infrequently ___Never

10. Are you currently in a romantic relationship? _____ Yes _____ No

11. On a scale of 1-10, how would you rate your relationship? _____

12. What significant life changes or stressful events have you experienced recently?

_____

_____

FAMILY MENTAL HEALTH HISTORY

Please identify if there is a family history of any of the following. How are they related?

Alcohol Abuse	_____ Yes	_____ No	_____
Anxiety	_____ Yes	_____ No	_____
Depression	_____ Yes	_____ No	_____
Domestic Violence	_____ Yes	_____ No	_____
Eating Disorders	_____ Yes	_____ No	_____
Obesity	_____ Yes	_____ No	_____
Obsessive Compulsive Behavior	_____ Yes	_____ No	_____
Schizophrenia	_____ Yes	_____ No	_____
Substance Abuse	_____ Yes	_____ No	_____
Suicide Attempts	_____ Yes	_____ No	_____

OTHER

THRIVE LIFE
COUNSELING & WELLNESS

What would you like to accomplish out of your time in therapy?

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

What do you consider to be some of your strengths?

_____

_____

Do you consider yourself to be spiritual or religious? _____ Yes _____ No

Are you currently employed? _____ Yes _____ No

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

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