Thrive Counseling, LLC

Client Psychosocial Intake Form

GENERAL INFORMATION

Date: ___________________ Referred By: ____

Full Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. ____

Name You Prefer: _______________________________ Age: _______ Date of Birth: __________________

Parent(s) Name(s), for Minor Client: ____

Race: ☐ White ☐ Black ☐ Latino ☐ Asian ☐ Other: ________________________ Sex: ☐ Male ☐ Female

CONTACT INFORMATION

Address: ____ Suite or Apt. #: __________________

City: ________________________ State: _____ Zip Code: __________ May we send mail here: ☐ Yes ☐ No

Home Phone: ____ May we leave a message here: ☐ Yes ☐ No

Mobile Phone: ____ May we leave a message here: ☐ Yes ☐ No

Email Address: ____ May we leave a message here: ☐ Yes ☐ No

EMERGENCY CONTACT

Name: ____ Relationship to You: ________________________

Mobile Phone: _________________________________ Home Phone: _________________________________

EMPLOYMENT INFORMATION

Employer: ____ Length of Employment: _______________

Occupation: ____ Average Hours Worked Per Week: _________

Annual Salary: ☐ $0 to $10,000 ☐ $10, 001 to $20, 000 ☐ $20, 001 to $40, 000 ☐ $40, 001 to $50, 000
☐ $50, 001 to $60, 000 ☐ $60, 001 to $80, 000 ☐ $80, 001 to $100, 000 ☐ More than $100,000

EDUCATION INFORMATION

Last Year of High School Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐ AA College: ☐ 1 ☐ 2 ☐ 3 ☐ 4
☐ Master's Degree ☐ Doctorate Degree ☐ Other: ___________________________________

Are You Currently in School: ☐ Yes ☐ No If Yes, What Level: __________________________________

Degree Pursuing: ____

Current or Previous Military Service: ☐ Yes ☐ No If Yes, What Service: ___________________________

Years of Service: _________ Highest Rank: ________________________ Combat Experience: ☐ Yes ☐ No

RELATIONAL INFORMATION

Current Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Relationship Status: ☐ Yes ☐ No

If No, Briefly Explain: ____

If Married, How Long: ___________ Number of Previous Marriages for You: ______ For Spouse: ______

If Separated or Divorced, How Long: _________________ If Widowed, How Long: __________________

With Whom Do You Currently Live (*Check all that apply*): ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s)
☐ Sibling(s) ☐ Boyfriend ☐ Girlfriend ☐ Roommate ☐ Other: ________________________

PARTNER INFORMATION

Full Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. ____

How Long Have You Known Your Partner: ____________ Age: ____ Preferred Name: _______________

Race: ☐ White ☐ Black ☐ Latino ☐ Asian ☐ Other: __________________ Sex: ☐ Male ☐ Female

Occupation: ______________________________________ Average Hours Worked Per Week: ________

Last Year of High School Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐ AA College: ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ Master's Degree ☐ Doctorate Degree ☐ Other: ___________ Currently in School: ☐ Yes ☐ No

Describe this Person: ____

CHILDREN

List Your Children, Living or Deceased. Include Children You Have Placed for Adoption, Aborted, Miscarried, or Still Birthed (*Use back if necessary)*

1. Name: __________________________ Current Age or Year of Death: _______ Sex: ☐ Male ☐ Female
   Relationship to You: ☐ Natural ☐ Step ☐ Adopted Occupation: ______________________________
   Living with You: ☐ Yes ☐ No Describe Him/Her: ____
2. Name: __________________________ Current Age or Year of Death: _______ Sex: ☐ Male ☐ Female
   Relationship to You: ☐ Natural ☐ Step ☐ Adopted Occupation: ______________________________
   Living with You: ☐ Yes ☐ No Describe Him/Her: ____
3. Name: __________________________ Current Age or Year of Death: _______ Sex: ☐ Male ☐ Female
   Relationship to You: ☐ Natural ☐ Step ☐ Adopted Occupation: ______________________________
   Living with You: ☐ Yes ☐ No Describe Him/Her: ____
4. Name: __________________________ Current Age or Year of Death: _______ Sex: ☐ Male ☐ Female
   Relationship to You: ☐ Natural ☐ Step ☐ Adopted Occupation: ______________________________
   Living with You: ☐ Yes ☐ No Describe Him/Her: ____

FAMILY OF ORIGIN

List Members of Your Immediate Nuclear Family or Origin *(Use back of necessary)*

1. Name: ___________________________ Current Age or Year of Death: ______ Sex: ☐ Male ☐ Female
   Relationship to You: ☐ Mother ☐ Father ☐ Sibling ☐ Step ☐ Other: ____________________
   Occupation: _________________________ Describe Him/Her: ________________________________
   Describe Nature of Relationship with Him/Her: ____
2. Name: ___________________________ Current Age or Year of Death: ______ Sex: ☐ Male ☐ Female
   Relationship to You: ☐ Mother ☐ Father ☐ Sibling ☐ Step ☐ Other: ____________________
   Occupation: _________________________ Describe Him/Her: ________________________________
   Describe Nature of Relationship with Him/Her: ____
3. Name: ___________________________ Current Age or Year of Death: ______ Sex: ☐ Male ☐ Female
   Relationship to You: ☐ Mother ☐ Father ☐ Sibling ☐ Step ☐ Other: ____________________
   Occupation: _________________________ Describe Him/Her: ________________________________
   Describe Nature of Relationship with Him/Her: ____
4. Name: ___________________________ Current Age or Year of Death: ______ Sex: ☐ Male ☐ Female
   Relationship to You: ☐ Mother ☐ Father ☐ Sibling ☐ Step ☐ Other: ____________________
   Occupation: _________________________ Describe Him/Her: ________________________________
   Describe Nature of Relationship with Him/Her: ____

MEDICAL INFORMATION

Primary Physician: ____ Phone: ____________________
Address: __________________________________ City: __________________ Zip Code: __________
Are You Currently Receiving Treatment: ◻ Yes ◻ No If Yes, Please Specify: ____________________
List any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas, or Related Treatments You've Had *(Use back if necessary)*: ____
Have You Ever Had a Miscarraige: ◻ Yes ◻ No ◻ N/A
Abortion: ◻ Yes ◻ No ◻ N/A If Yes, ◻ Medical ◻ Non-Medical When: __________ Age: _____
Rate Your Physical Health: ◻ Very Good ◻ Good ◻ Average ◻ Declining ◻ Poor ◻ Very Poor
What Positive Things do You do to Impact Your Physical Health: ______________________________

MEDICATION INFORMATION

List All Current Medications You are Taking, Including Those You Seldom Use or Take Only as Needed
1. Medication: ___________________________________ Dosage: ________________
   Improves/Prevents/Controls: _____________________________ Treating: _______________________
2. Medication: ___________________________________ Dosage: ________________
   Improves/Prevents/Controls: _____________________________ Treating: _______________________
3. Medication: ___________________________________ Dosage: ________________
   Improves/Prevents/Controls: _____________________________ Treating: _______________________
4. Medication: ___________________________________ Dosage: ________________
   Improves/Prevents/Controls: _____________________________ Treating: _______________________

SUBSTANCE USE

Do You Drink Alcohol or Use Drugs: ◻ Alcohol ◻ Drugs ◻ Both ◻ I Do Not Drink Alcohol or Use Drugs
Do You Smoke Tobacco: ◻ Yes ◻ No
If You use Alcohol or Drugs, What Kind do You use *(Check all that apply)*:
◻ Beer ◻ Wine ◻ Liquor ◻ Marijuana/Pot/Hash/etc ◻ Cocaine/Crack/etc ◻ Sedatives/Valium/etc
◻ Amphetamines/Speed/Meth/etc ◻ Opiods/Herion/Opium/etc ◻ Hallucinogens/Acid/Ecstasy/etc
◻ Inhalant/HuffingWhipits/etc ◻ Phencyclidine/Mushrooms/etc ◻ Over the Counter/Prescription Meds
If You use Alcohol or Drugs, How Often do You use Them: ◻ Every Day ◻ Several Times per Week
◻ Several Times per Month ◻ Once or Twice per Month ◻ Several Times per Year ◻ Once per Year
Have You Ever Felt Like You Should Cut Down on Your Alcohol or Other Drug Use: ◻ Yes ◻ No
If Yes, Explain: ____
Has a Friend or Relative Discussed Concerns About Your Use: ◻ Yes ◻ No
If Yes, Explain: ____
Have You Ever Felt Guilty About Your Drinking or Drug Use: ◻ Yes ◻ No
If Yes, Explain: ____
Have You Ever Had to Take a Drink or Use a Drug the Next Day to Steady Your Nerves: ◻ Yes ◻ No
If Yes, Explain: ____
Is There a History if Problems with Alcohol or Drug Use in Your Family: ◻ Yes ◻ No
If Yes, Explain: ____
Are You in Recovery from any Addictive Behavior: ◻ Yes ◻ No Explain: ________________________
Do You Engage in any of the Following Behaviors in such a way that it May be an Issue or Concern:
◻ Gambling ◻ Spending ◻ Sexuality ◻ Eating ◻ The Internet ◻ Exercise ◻ Other: ______________

ABUSE HISTORY

Have You Ever Been Physically, Sexually, Emotionally, or Mentally Abused: ☐ Yes ☐ No

If Yes, Explain: ______________________________

LEGAL HISTORY/SOCIAL AGENCY INVOLVEMENT

Do You Have Past/Current Legal Involvement: ☐ Yes ☐ No

If Yes, Explain: ______________________________

Have You Ever Been Involved with the Department of Children and Families (DCF) or a Similar Agency in Another State: ☐ Yes ☐ No

If Yes, Explain: ______________________________

Have You Ever Been Involved in any Kind of Domestic Violence: ☐ Yes ☐ No

If Yes, Explain: ______________________________

CURRENT STATUS

Check All of the Following Problems that Apply to You and/or Your Family:

Stress --------------- ☐ You ☐ Family
Panic --------------- ☐ You ☐ Family
Anxiety ------------ ☐ You ☐ Family
Nervousness ------ ☐ You ☐ Family
Shyness ------------ ☐ You ☐ Family

Physical Abuse --- ☐ You ☐ Family
Sexual Abuse ----- ☐ You ☐ Family
Emotional Abuse- ☐ You ☐ Family
Verbal Abuse ----- ☐ You ☐ Family

Trauma ------------- ☐ You ☐ Family
Sexual Trauma --- ☐ You ☐ Family
Head Trauma ----- ☐ You ☐ Family

Anger --------------- ☐ You ☐ Family
Temper ------------- ☐ You ☐ Family
Aggressiveness --- ☐ You ☐ Family
Loss of Control --- ☐ You ☐ Family
Impulsiveness----- ☐ You ☐ Family
Compulsivity ----- ☐ You ☐ Family

Apathy ------------- ☐ You ☐ Family
Unhappiness ------ ☐ You ☐ Family
Loneliness --------- ☐ You ☐ Family
Hopelessness------ ☐ You ☐ Family
Defective Feelings ☐ You ☐ Family
Unwanted Thoughts ☐ You ☐ Family
Inferiority Feelings ☐ You ☐ Family
Depression -------- ☐ You ☐ Family
Self Injury --------- ☐ You ☐ Family
Suicidal Ideation - ☐ You ☐ Family
Suicide Attempt -- ☐ You ☐ Family
Homicidal Ideation ☐ You ☐ Family

Ambition----------- ☐ You ☐ Family
Concentration ----- ☐ You ☐ Family
Racing Thoughts - ☐ You ☐ Family
Making Decisions ☐ You ☐ Family
Guilt ---------------- ☐ You ☐ Family

Grief ---------------- ☐ You ☐ Family
Recent Death------ ☐ You ☐ Family
Terminal Illness -- ☐ You ☐ Family

Marriage ----------- ☐ You ☐ Family
Pregnancy --------- ☐ You ☐ Family
Children------------ ☐ You ☐ Family
Being a Parent ---- ☐ You ☐ Family

Communication -- ☐ You ☐ Family
Friends ------------- ☐ You ☐ Family

Legal Matters ----- ☐ You ☐ Family
Finances ----------- ☐ You ☐ Family
Trouble with Job - ☐ You ☐ Family
Career Choices --- ☐ You ☐ Family

Sexual Problems - ☐ You ☐ Family
Pornography ------ ☐ You ☐ Family

Alcohol Use ------- ☐ You ☐ Family
Drug Use----------- ☐ You ☐ Family
Nicotine Use ------ ☐ You ☐ Family

Bad Dreams ------- ☐ You ☐ Family
Memory ------------ ☐ You ☐ Family
Eating Problems -- ☐ You ☐ Family

LEVEL OF DISTRESS

On a Scale from 1 to 10, Indicate Your Level of Distress *(1=Very Little Distress; 10=Extreme Distress)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Are You Currently Experiencing Any Suicidal Thoughts: ☐ Yes ☐ No

Have You Experienced Suicidal Thoughts in the Past: ☐ Yes ☐ No

Have You Ever Attempted Suicide: ☐ Yes ☐ No

If Yes, When and How: ____________________

Have Any of Your Friends or Family Members Ever Completed or Attempted Suicide: ☐ Yes ☐ No

If Yes, When and Who: ____________________

PRESENTING CONCERN AND GOALS

Describe Your Reason for Coming to Counseling: ____________________

What Have You Done About it up to this Point: ____________________

What is Your Desired Result of Counseling: ____________________

How Long do You Believe Counseling Should Last: ____________________

What Information Should be Known at the Outset of Counseling: ____________________

PERSONALITY INFORMATION

Mark All Words Which You Feel Best Describe You:

☐ Active ☐ Ambitious ☐ Self-Confident ☐ Persistent ☐ Nervous ☐ Hardworking ☐ Dedicated
☐ Impatient ☐ Impulsive ☐ Moody ☐ Excitable ☐ Imaginative ☐ Calm ☐ Serious ☐ Easygoing
☐ Shy ☐ Good-Natured ☐ Introvert ☐ Extrovert ☐ Depressed ☐ Likeable ☐ Leader ☐ Quiet
☐ Submissive ☐ Self-Conscious ☐ Insecure ☐ Lonely ☐ Sensitive ☐ Passive ☐ Indifferent

Pick 3-5 Other Words to Describe Yourself: ____________________

Pick 5-7 Words Others Would Use to Describe You: ____________________

PREVIUS COUNSELING

Have You Ever had a Severe Emotional Upset? ☐ Yes ☐ No Explain: ____________________

List any Previous Counseling, Treatment, or Residential/In-Patient Care You Have Received:

1. Therapist: ____________________ Location: ____________________
   Dates Attended: ____________________ Reason: ____________________
2. Therapist: ____________________ Location: ____________________
   Dates Attended: ____________________ Reason: ____________________

What was the Outcome of any Prior Counseling: ____________________

EMOTIONAL HEALTH

How Many Supportive People (Who You Can Depend On) do You Currently Have in Your Life:

☐ None (0) ☐ Some (1-5) ☐ Average (6-10) ☐ Many (10+)

Have You Ever Attended a Support Group Addressing the Topic(s) for Which You are Seeking Counseling: ☐ Yes ☐ No Explain: ____________________

Have You Ever Been Hospitalized for Emotional/Psychological Concerns: ☐ Yes ☐ No

If Yes, Explain: ____________________

What Positive Things do You do to Impact Your Emotional Health: ____________________

____

RELIGIOUS BACKGROUND/SPIRITUALITY

Do You Subscribe to a Religion/Form of Spirituality: ◻ Yes ◻ No Explain: __________________

Do You Believe in a Higher Power: ◻ Yes ◻ No ◻ Uncertain

Is Your Religion/Spirituality a Source of Strength: ◻ Yes ◻ No ◻ Uncertain

Briefly Describe the Religious/Spiritual Environment of Your Home as You Were Growing Up:

____

Do You Regularly Attend a Place of Worship: ◻ Yes ◻ No If Yes, Where: __________________

Do You Have a Spiritual Support System: ◻ Yes ◻ No If Yes, Who: ________________________

Would You Like Your Counselor to Address how Your Religion/Spirituality Might Assist You in the Counseling Process: ◻ Yes ◻ No ◻ Uncertain

This concludes the psychosocial portion of your intake process. Thank you for taking the time to complete this inventory. The information that you have supplied will help to provide you with the best service possible.