**Thrive Family Co.**

1152 2nd Avenue

Ladysmith, BC, V9G 1A1

Phone: (250) 924-4226

**Client Intake**

| **Demographics** | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | | | Date of Intake: | | |
| Address: | | | | | | | |
| Email: | | | | Phone #: | | | |
| Leave Message Okay: | | * Yes | * No | Text Reminder Okay: | | * Yes | * No |
| Marital Status: ----- | | DOB: | | Gender: ----- | | Ethnicity: ----- | |
| Emergency Contact: | | | | | Relationship to You: ----- | | |
| Email: | | | | Phone #: | | | |
| Referral Source: | | | | | | | |
| Previous Counseling: | | * Yes | * No |  | | | |
| If yes, provide dates: | | | | | | | |
| What did you find most helpful? | | | | | | | |
| What did you find least helpful? | | | | | | | |

| Reason for Seeking Therapy | |
| --- | --- |
|  | |

| **Medical/Mental Health History** | | | | | | | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Primary Care Provider: | | | | | | | | | | | | | | Phone #: | | | | | | | |
| Allergies: | | | | | | | | | | | | | | Last Physical: | | | | | | | |
| How would you rate your overall health? | | | | | * Excellent | | | | * Good | | | | * Fair | | | | * Poor | | | | |
| Mental Health Diagnosis: | | | | | | | | | | | | | | | | | | | | | |
| Medical Diagnosis: | | | | | | | | | | | | | | | | | | | | | |

| **Medications** | | | |
| --- | --- | --- | --- |
| List all known prescriptions, over the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements. *Attach list if more room is needed.* | | | |
| **Medication** | **Dose** | **Frequency** | **Prescribed By** |
|  |  |  |  |
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|  |  |  |  |
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|  |  |  |  |

| **Surgeries/Hospitalizations**  (Include Inpatient Treatment/Hospitalizations for Mental Health Purposes) **Date** | |
| --- | --- |
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|  |  |

| **Pain** | | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Are you experiencing Pain? | | | | | * Yes | | * No | | Location of Pain? | | | | | | | |
| How Long? | | | | | Medication(s) Used for Pain? | | | | | | | | | | | |
| Pain Level Today: | | | | | | | | | | | | | | | | |
| Mild | | | * 1 | * 2 | * 3 | * 4 | * 5 | * 6 | * 7 | * 8 | * 9 | * 10 | | Severe | | |

| **Women’s Health** | | |
| --- | --- | --- |
| # of Pregnancies: | # of Stillbirths: | # of Miscarriages: |
| Have you experienced the loss of a child: | | |

| **Health** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Diet:** How would you rate your diet? | | * Good | * Fair | * Poor | | | | |

| Purge: | * Y | * N | Restrict: | * Y | * N | Overeat: | * Y | * N | Binge: | * Y | * N |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Exercise:** Do you exercise regularly? | | | | * Yes | | * No | What kind of exercise? | | | | |
| Duration: | | | |  | | Frequency: | | | | | |
| **Sleep:** How many hours, on average do you sleep a night?   * Trouble Falling Asleep * Trouble Staying Asleep | | | | | | | | | | | |

| **Physical Symptoms** | | |
| --- | --- | --- |
| * Headaches * Muscle Tension * Chest Pains * Numbness * Sweating * Shortness of Breath * Dizziness | * Sexual Problems * Rapid Heartbeat * Trembling/Shaking * Joint/Muscle Pain * Heart Pounding * Diarrhea * Fainting | * Fatigue * Vision Changes * Blackouts * Chills/Hot Flashes * Stomach Aches * Nausea * Other: |

| **Immediate Family Members Living with Client** | | | | |
| --- | --- | --- | --- | --- |
| Name | Gender | Age | Relationship to Client | Living with Client |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

| **Family Mental Health History** | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Issue/Diagnosis | Self | Father | Mother | Sister | Brother | Child | Grandparent |
| Depression |  |  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |  |  |
| Bipolar Disorder |  |  |  |  |  |  |  |
| Schizophrenia |  |  |  |  |  |  |  |
| ADHD / ADD |  |  |  |  |  |  |  |
| Trauma History |  |  |  |  |  |  |  |
| Abusive Behavior |  |  |  |  |  |  |  |
| Alcohol Abuse |  |  |  |  |  |  |  |
| Drug Abuse |  |  |  |  |  |  |  |
| Suicide |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |

| **Mood (Past 1-2 Weeks)** | **Behavioral Symptoms (Past Month)** | |
| --- | --- | --- |
| * Calm * Happy * Sad * Angry * Anxious * Frustrated * Worried * Hopeless * Helpless * Fearful * Excited * Depressed * Other | * Sleep Issues * Motivation * Shame * Guilt * Concentration * Racing Thoughts * Loss of Sex Drive * Impulsiveness * Fatigue * Poor Judgment * Appetite Change * Periods of High/Low | Notes: |

| **Risk Assessment** | | | | |
| --- | --- | --- | --- | --- |
| **Question** | **Yes** | **No** | **Today** | **Recently** |
| Been so distressed you seriously wished to end your life? |  |  |  |  |
| Do you have a specific plan how you would kill yourself? |  |  |  |  |
| Do you have access to weapons/means of hurting yourself? |  |  |  |  |
| Have you made a serious suicide attempt? |  |  |  |  |
| Have you purposely done something to hurt yourself/self harm? |  |  |  |  |
| Have you heard voices telling you to hurt yourself? |  |  |  |  |
| Thoughts of killing or seriously hurting someone else? |  |  |  |  |
| Heard voices telling you to hurt others? |  |  |  |  |

| **Social History Additional Notes** | |
| --- | --- |
| Are your parents divorced?   * Yes * No |  |
| Are childhood events contributing to current problems?   * Yes * No |  |
| Briefly describe your childhood (happy, chaotic, troubled): | |
| Have you experienced any abuse (physical, sexual, verbal?   * Yes * No |  |
| How satisfied are you with your current family life?   * Satisfied * Unsatisfied |  |
| How satisfied are you with the support received from family and friends?   * Satisfied * Unsatisfied |  |
| How satisfied are you with your quality of life?   * Satisfied * Unsatisfied |  |
| Do you enjoy leisure/recreational activities?   * Yes * No |  |
| Are you spiritual?   * Yes * No |  |
| Do you have any habits you’d like to change?   * Yes * No |  |

| **Education/Work History** | | | | | |
| --- | --- | --- | --- | --- | --- |
| Years of Education: | | Degree(s): | | | |
| Occupation: | | Employment: ----- | | | |
| How many jobs have you had? | | Been Fired? | * Yes | * No |  |

| **Chemical Use History** | | | | |
| --- | --- | --- | --- | --- |
| **Chemical Use** | **Yes** | **No** | **Past** | **Currently** |
| Regularly use alcohol (more than 2x a week)? |  |  |  |  |
| Had trouble (legal/family/work) because of alcohol? |  |  |  |  |
| Felt you should cut down on drinking? |  |  |  |  |
| Felt bad or guilty about drinking? |  |  |  |  |
| Ever drank first thing in the morning? |  |  |  |  |
| Used medications not prescribed to you? |  |  |  |  |
| Taken more than the recommended daily dosage of meds? |  |  |  |  |
| Do you use marijuana? |  |  |  |  |
| Have you ever used a needle to get high? |  |  |  |  |
| Ever use more than 1 chemical at a time? |  |  |  |  |
| Do you avoid family activities so you can use? |  |  |  |  |
| Do you use it to improve your emotions, such as when you’re sad or depressed? |  |  |  |  |

| **Goals for Therapy** |
| --- |
| 1.  2.  3. |
| Is there anything else you would like us to know? |

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Client Signature Printed Name Date