Thrive Counseling Center
Individual Client Intake Form

Date _____

Client information:
Client's Name_____
Client's Age_____Client's Date of Birth_____
Address _____
Preferred Phone Number_____
OK to call _____OK to leave message_____OK to text _____
Email address _____
OK to email (for billing and session reminder) _____
Occupation _____
Employer _____ Length of time _____
Marital status _____ If married, how long
If Client is a minor, name of guardian (or responsible adult)
Emergency contact _____ Phone _____
List everyone living in your house and their ages_____

Church affiliation (if any) _____
Referred by _____

Medical/Mental Health history:
Medical problems_____
Medications you are taking _____
Alcohol use/abuse_____

Previous counseling experience:

Name of counselor/facility Dates Reason treated

Was counseling helpful for you? Why or why not?

What made you decide to seek out counseling this time?

What are your goals for counseling?

List any past or previous events that you feel would be helpful for me to know (abuse, relationship or work issues, traumatic events, illness):

Circle any symptoms that you are experiencing:

Depression Anxiety Loneliness

Sleep too much Can’t sleep Crying spells

Nervousness Anger outburst Jealous

Loss of energy Confusion Suspicious

Increased sex drive Oversensitive Headaches Loss of appetite Fears or Phobias Hallucinations

Decreased sex drive Work Problems

Suicidal thoughts Trouble getting along with others

Briefly describe the issue(s) you circled: