Nick K. Choate, LPC-MHSP, NCC
THRIVE Counseling | Workshops
9025 Overlook Blvd, Suite 200
Brentwood, TN 37027
Office Phone – (615) 852-8281

Initial Therapy Intake Form

Client Information:

Client's Name_____
Client's Age_____ Client's Date of Birth_____
Address_____
Preferred Phone Number_____
How did you hear about our counseling services? _____
Occupation_____ Employer_____
Religious Preference (if any) _____
If client is a minor, name of responsible adult (guardian) _____
Emergency Contact person: _____Phone: _____

Therapy Goals and Client Stressors

What do you wish to achieve through therapy at this time?_____
_____
_____
_____
_____
_____

Briefly describe the history of this problem. _____
_____
_____
_____
_____
_____

Presently, and during the last two years, what are/have been some of the stressful events in your life (death of a loved one, loss of a relationship, job loss, family difficulties, disappointments, etc)? _____
_____
_____
_____

How do you usually handle stressful events in your life (ie: effective coping skills, ineffective coping skills, dangerous or harmful behaviors, acting out, isolating, etc): ____
_____
_____
_____
_____

Do you have a trauma or abuse history (victim of or witness to physical or sexual abuse, domestic violence, traumatic losses, difficult upbringing, etc). If yes, please describe:
_____
_____
_____
_____
_____

Medical/Mental Health History:

Any Previous Therapy/Counseling: **Yes No**
If yes, what type of therapy and how long did you attend? _____
_____
Was therapy beneficial to you? Why did you feel it helped/didn't help? _____
_____
_____
Are you currently in treatment with any other counselor or psychiatric provider? _____
Medical Problems (describe):_____
History of any hospitalizations (medical and/or psychiatric):_____
_____
Name of Primary Care Physician:_____Phone:_____
Name of Psychiatrist (if applicable): _____ Phone: _____

Suicide Information:	**Check all that apply:**
None: no suicidal thoughts	□ I have never had thoughts of suicide
Mild: some thoughts, no plan	□ I am experiencing these thoughts now □ I have experienced these thoughts in the past. □ I last experienced this on: Date:_____
Moderate: some thoughts, vague plan, low levels of lethality	□ I am experiencing these thoughts now □ I have experienced these thoughts in the past □ I last experienced this on: Date:_____

Severe: significant thoughts, plan is specific and lethal	□ I am experiencing these thoughts now □ I have experienced these thoughts in the past □ I last experienced this on: Date:_____

Have you ever actually attempted suicide at any time in your life? **Yes** **No**
If yes, when and describe the circumstances leading up to the attempt as well as follow-up after the attempt:

_____
_____
_____
_____

Your Relationships

___Single ___Married ___Divorced ___Remarried ___Separated
___Widowed ___Engaged ___Living Together

Spouse's/Partner's name (if this applies): _____
Length of time together:_____
Your children's names and ages (if applicable): _____
Who currently lives in your home: _____
Please identify any areas of strength in your present relationship: _____

_____
_____
_____

Please identify any areas of need or struggle in your present relationship: _____

_____
_____
_____

Please identify any areas of significant conflict or trauma that you have experienced in your past or present relationships (ie: adultery/affairs, financial problems, sexual addiction, alcohol and/or drug addictions, domestic violence, etc):

_____
_____
_____
_____

Your Substance Use/Addiction History

Prescription Drug Use (Current names and doses): _____

_____
Previous Prescription Drug Use (names and doses): _____
_____
Any side effects?_____
History of Illegal Drug use? (describe):_____
Current Illegal Drug use? (describe): _____
Alcohol use/abuse (describe frequency and reason for use):_____
_____
Do you struggle with other addictive behaviors (overeating, constantly working, extreme shopping binges, gambling, sexual acting out, etc)? If yes, please describe. _____
_____
_____

Sleep & Exercise Inventory

On average, how many hours of sleep do you get each night? _____
How would you describe the quality of your sleep? (Circle One) Good Fair Poor
How would you describe your overall energy level each day?
_____
_____

How would you describe your dreams? (Check All That Apply) _____ I don't dream
____ I can't remember them _____ I have vivid dreams _____ I have nightmares
____ I have a recurrent dream(s) about _____

In an average week, how many hours of increased physical activity/exercise do you get?
_____
What types of exercise (i.e. walking, hiking, biking, gym, etc.) do you prefer?
_____
_____

Your Spirituality

What (if any) was your spiritual upbringing? _____
What (if any) is your current spiritual orientation? _____
Check all phrases that describe your current religious experience:

___Atheist	___Agnostic	___Curious
___Seeking God	___Spiritual…not religious	
___Pray often	___Skeptical	___Closed towards God
___Open towards God	___God is distant	___God loves me
___God is good	___God is cruel	___Communal Worship
___Stagnant	___Charismatic	___Fearful of God
___Strong Faith		

Symptom Assessment:

Check all of the following that apply to you over the last month. Next to any that are checked, please mark 1-5 to assign the severity to each symptom. (i.e. 1=low severity, 5=very severe):

Emotional Symptoms-

__ anger __ anxiety __ extreme mood shifts
__ irritability __ worrying __ frustration
__ hopelessness __ helplessness __ fears
__ depression __ apathy __ lack of emotions
__ feelings of inferiority __ panicky
__ guilt __ unable to have a good time
__ other (specify) _____

Cognitive Symptoms-

__ problems with concentration __ inattention
__ difficulty making decisions __ distractibility
__ racing thoughts __ memory problems
__ repeated unwanted thoughts __ hallucinations
__ recurring nightmares __ other _____

Physical Symptoms-

__ increase or decrease in appetite __ shaky hands/feet
__ tearfulness/crying spells __ racing heart rate
__ sweating/chills __ body pain/numbness
__ stomach or intestinal distress __ frequent or severe headaches
__ sleep difficulties __ muscle tension
__ dizziness/fainting __ other _____

Behavioral Symptoms-

__ hyperactivity __ impulsivity __ binge eating/overeating
__ suicidal gesture/attempt history __ present suicidal thoughts
__ verbal aggression __ physical aggression
__ social withdrawal __ induced vomiting
__ self-injury __ increased alcohol/drug use
__ disorganization __ oppositional/defiant
__ lying/deceitfulness __ sexual problems
__ financial problems __ avoidance of school or job
__ relationship problems __ other_____

Upon my signature below, I hereby attest that all the information furnished is true and correct to the bet of my understanding.

Client Signature (if completed by client)	**Date**
Signature of Legal Guardian of Client under the age of 16	**Date**
Counselor Signature (if completed by counselor)	**Date**