Megan Ness, Registered Psychotherapist

Thrive Counseling Group, LLC

Phone: 720.204.1757

Intake Form

Client Name: _____
Last First Middle Initial

Present Address: _____
Street City State Zip Code

Phone: _____ Email: _____

May we contact you/leave a message at home? ☐ Yes ☐ No May we send you email? ☐ Yes ☐ No

Instructions for phone messages: _____ Cell: _____

Contact/Messages on cell ok? ☐ Yes ☐ No

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Relationship Status (single, divorced, married, etc.): _____ Spouse: _____

Who is responsible for the bill? _____ Are you a student? ☐ Yes ☐ No

How did you hear about Megan Ness/ Thrive Counseling Group? _____

Employer Name: _____ Phone: _____

May we call you at work? ☐ Yes ☐ No Instructions for phone messages: _____

*****Who should we contact in case of emergency? _____ Phone: _____**

Inventory of Concerns

Identify if you have experienced any of the following the past month:

Yes

- ☐ Depressed Mood
- ☐ Suicidal Thoughts
- ☐ Appetite Changes
- ☐ Difficulty Concentrating
- ☐ Mood Swings

- ☐ Tension/Anxiety
- ☐ Hearing/Seeing Things Others Cannot
- ☐ Memory Problems
- ☐ Hostility
- ☐ Trouble With The Law

- ☐ Conflict With Authority
- ☐ Feeling That You Have Left Your Body
- ☐ Employment/School Related Difficulty
- ☐ Family Problems
- ☐ Abuse (pysical, verbal, sexual)

Yes

- ☐ Hopelessness
- ☐ Disturbed Sleep
- ☐ Significant Weight Loss/Gain
- ☐ Agitation
- ☐ Thoughts You Cannot Stop

- ☐ Significant Fear
- ☐ Behavior You Cannot Stop
- ☐ Feeling That Others Are After You
- ☐ Violence
- ☐ Isolation

- ☐ Desire to Harm Others
- ☐ Health Problems
- ☐ Guilt
- ☐ Marital Conflict
- ☐ Other:_____

Have you ever been sexually assaulted/abused? ☐ Yes ☐ No

Have you ever been physically assaulted/abused? ☐ Yes ☐ No

Social History

List immediate family members (include parents, siblings, children, and other important people):

Family Member	Age	Relationship	Do they live with you? Y/N

Describe any family history of alcoholism, drug use, depression, abuse, suicide, mental illness, or other significant difficulty:

☐ None

Describe any medical problems you have (including allergies):

☐ None

List any medications you currently take:

☐ None

List and describe any past or present therapy or counseling in which you have been involved:

☐ None

Alcohol Use

☐ Never ☐ Less than 1 time/month ☐ 1-4 times per month ☐ 2-3 times per week ☐ Daily

Alcohol Consumption Per Use: ☐ None ☐ 1-2 Drinks ☐ 3-4 Drinks ☐ 5 or more drinks

Have you experienced any of the following related to alcohol use?

☐ Binges ☐ Job Problems ☐ Sleep Disturbances ☐ Physcial Withdrawel ☐ Hangovers

☐ Arrests ☐ Blackouts ☐ Medical Complications ☐ Assaults ☐ Passing Out

☐ Seizures ☐ Inability to stop ☐ Interpersonal Conflict ☐ Concerns about drinking

What other substances do you use, or have you used in the past **6 weeks** (check all that apply)?

☐ Cigarettes ☐ Caffeine ☐ Marijuana ☐ Sedatives ☐ Hallucinogens

☐ Cocaine ☐ Opiates ☐ Inhalants ☐ Stimulants ☐ Prescription Drugs

☐ Other_____

☐ None

Rank your current problem as you see it:

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10
Best Ever									Worst Ever

Where would you like the problem to be (i.e. when will you know when the counseling is over)?

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10
Best Ever									Worst Ever

Describe the Problem and Your Goals for Therapy:

_____

_____

_____

_____

_____

_____

_____

It is highly recommended that you consider a medication evaluation with a physician or psychiatrist if you are struggling with depression, anxiety, or other mental health issue that can be effectively treated with medication.

Signature of person completing information:_____ Date: _____