**Adult THRIVE Program Assessment Form**

Name:_____ Date:_____

Date of Birth:_____ Gender: _____

Address: _____

Phone Number(s), if it is o.k. to leave a message: _____

Email Address:_____

Please fill in the blanks below from the time of your conception to present day with the significantly threatening, frightening, hurtful or difficult events or situations that you have experienced. If you do not recall the event, but were told about it (e.g., in utero, birth trauma, etc.) please list it, as well.

**Please circle the things that you believe have been the most impacting to you.**

Details are not needed, at this point. However, feel free to provide more information on a separate sheet, if you wish.

Example: 11-15 years of age: bullied in school, fights between parents,

0-5 years of age:_____

_____

6-10 years of age:_____

_____

11-15 years of age:_____

_____

16-20 years of age:_____

_____

21-25 years of age:_____

_____

26-30 years of age:_____

31-35 years of age:

36-40 years of age:

41-45 years of age:

46-50 years of age:

51-55 years of age:

56 years of age and older:

What has caused you to seek treatment now?

Are you currently dependent on drugs or alcohol?

Please list any prescription medications you take currently:

Please list your 5 main symptoms in order of their distress to you.

What diagnoses have you received in the past?

Name and relationship of the person who completed this form, if not the treatment candidate: