NWC COUNSELING
COUNSELING INDIVIDUALS COUPLES FAMILIES
1 Windsor Cove | Suite 303 | Columbia SC | 29223
nwccounseling.org • admin@nwccounseling.org • 803.851.6801

Adult Intake Form

IDENTIFYING INFORMATION

Name _____ DOB _____
Address_____
City _____State _____ Zip_____
Telephone (Home) _____ (Cell)_____
☐ Okay to leave voicemails ☐ Okay to send text messages
Email (required) _____
☐ Okay to email about services ☐ Okay to send monthly newsletter, events, or offerings
Age _____ Sex _____ Race_____

REFERRAL SOURCE

☐ EAP/ Insurance ☐ Doctor's office ☐ Friend ☐ Social Media
☐ Website _____ ☐ Other:_____

PAYOR INFORMATION

How do you plan to pay for services? ☐ EAP ☐ Insurance ☐ Self-pay
If **EAP** enter the name of your EAP provider _____
List the authorization code if given one
_____
If **Insurance** enter the name of your insurance provider _____
Member ID# _____DOB of policy holder _____
Do you have a secondary insurance? Enter the name here _____
Member ID# _____ DOB of policy holder _____

PHYSICAL HEALTH & HISTORY

Describe general health _____ _____

Are you now under doctor's care? ☐ Yes ☐ No If yes, name of doctor & reason for care:
_____

Are you taking any medications? ☐ Yes ☐ No If yes, what kind (name and dosage)

Medication Name and reason	Dosage	Side Effects

Were you diagnosed with any childhood diseases? ☐ Yes ☐ No

If yes, please specify _____

Have you ever been hospitalized for a physical illness? ☐ Yes ☐ No

If yes, please describe

_____

Did your mother have complications while she was pregnant or during her delivery with you?

_____

How would you describe the stages of your developmental history?

	Unknown	**Poor**	**Average**	**Above average**
Infancy (up to 12 months old)				
Middle childhood (1- 11)				
Adolescence (12- 17)				
Young adulthood (18-25)				

Any recent major illnesses or surgeries? ☐ Yes ☐ No - If yes _____

Any recurrent or chronic conditions? ☐ Yes ☐ No - if yes _____

SUBSTANCE USE/HISTORY

Are you being referred for services due to substance use? ☐ Yes ☐ No

Do you think you have a problem with substance use? ☐ Yes ☐ No

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Substance	Age of first use	Date of last use	How often?	How much per time do you use?
Nicotine				
Marijuana				
Alcohol				
Stimulants (cocaine, meth, amphetamines)				
Opiods (painkillers, oxy, heroin)				

For any substances acknowledged check any that apply to you:

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
Many of my friends and/or family use					
I have increased my use					
I want to stop using or have tried to stop					
I spend a lot of time trying to get it or hide it from others					
I have a strong craving/desire for it					
I use it even though it affects my role as a parent, friend, worker, etc.					
I sacrificed things to use it					
I use it while taken other medications					
I have used It while driving or in risky situations					
I have a high tolerance for it					
I have experienced withdrawal symptoms from it					

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PSYCHOLOGICAL INFORMATION

Have you ever been hospitalized for a mental illness or substance use? ☐ Yes ☐ No

If yes, please describe

_____

_____

Have you ever had any previous counseling therapy OR psychiatric care? ☐ Yes ☐ No

If yes, please describe

Name of counselor or practice	City, State	Duration (From mm/yy To mm/yy)	Reason

Have you had any thoughts of suicide? ☐ Yes ☐ No If yes, describe:

_____

_____

Have you ever attempted suicide? ☐ Yes ☐ No If yes, describe:

_____

_____

Do you currently have any suicidal or homicidal thoughts? ☐ Yes ☐ No

Do you have any history sexual trauma? ☐ Yes ☐ No If, yes describe:

_____

_____

Do you have any history physical abuse? ☐ Yes ☐ No If, yes describe:

_____

_____

Do you have any history of violent behavior? ☐ Yes ☐ No If, yes describe:

_____
_____

What are some emotional health symptoms you are experiencing (ie. Crying spells, moodiness, overwhelmed, racing thoughts, lack of sleep, etc.)?

_____
_____
_____
_____

What would you like to experience that is different from what you are currently experiencing?

_____
_____

How long has this been a concern for you? _____

How do you think therapy can help with these concerns?

_____
_____

FAMILY HISTORY

Family	Living (Y/N)	Age	City, State they currently reside in	How would you describe your relationship?
Father				
Mother				
Step-parents				
Other important family members				

	How many	Ages	How would you describe your relationship?
Siblings			
Children			

History of family substance use or mental health illness ☐ Yes ☐ No If yes, describe:
_____
_____

History of family domestic violence ☐ Yes ☐ No If yes, describe:
_____
_____

How was love expressed in your family?
_____
_____

How was discipline handled in your family?
_____
_____

Parent's divorced ☐ Yes ☐ No ☐ N/A If yes, describe how old you were:____

Are you parents remarried? ☐ Yes ☐ No ☐ N/A If yes, describe the relationship with your step-parents?

_____

If deceased how old were you at the time and cause of death:
_____

SOCIAL

How would you describe your peer group (friends): Check all that apply - ☐ None ☐ I don't trust people
☐ Group of few close and trusted friends ☐ Many friends and acquaintances ☐ Generally well liked and likable

How would you like us to identify your sexual orientation? ☐ Heterosexual ☐ Lesbian ☐ Bisexual ☐ Gay ☐ Questioning ☐ Transgendered ☐ Transsexual ☐ Other: _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

If married or in a relationship, partner's name _____Age _____
How would you describe your current relationship?
_____
_____

Describe your history of romantic relationships:

_____
_____

Describe common problems areas or stressors in relationships for you:

_____
_____

SPIRITUALITY

Religious upbringing _____ Present Affiliation_____

Is this an important part of your life? ☐ Yes ☐ No Explain your answer:
_____

_____ _____

EDUCATION/VOCATION

What is your highest year of education completed? _____

Did you receive any special education or needs in school ☐ No ☐ Yes – please specify _____

Military Service: Years _____ Rank_____

If Discharged, Date _____ ☐ Honorable ☐ Dishonorable

Occupation _____ How long? _____

How would you rate your job satisfaction? ☐ Good ☐ Fair ☐ Poor

If presently unemployed describe the situation:
_____

_____