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

Parent Intake Form

IDENTIFYING INFORMATION

Child's name _____ Date _____

DOB _____ Age ____ Sex ____ Race _____

Your name _____

DOB _____ Age ____ Sex ____ Race _____

Address _____

City _____ State_____ Zip _____

Telephone (Home) _____ (Cell) _____

Email (required) _____

Consent to leave……..

Voicemails: ☐ Yes ☐ No Text messages: ☐ Yes ☐ No Email: ☐ Yes ☐ No

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 you have been given _____

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

Describe child's general health _____

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Is your child now under doctor's care? ☐ Yes ☐ NoIf yes, name of doctor & reason for care:

_____

_____

Is your child taking any medications? ☐ Yes ☐ No If yes, what kind (name and dosage)

Medication Name	Dosage	Side Effects

Has your child ever been hospitlized for a physical illness? ☐ Yes ☐ No

If yes, please describe

_____

_____

Any recent major illnesses or surgeries? _____

Any recurrent or chronic conditions? _____

Substance	Last use	How often	How much
Nicotine			
Drugs			
Alcholol			
Other			

PYSCHOLOGICAL INFORMATION

Has your child ever been hospitlized for a mental illness? ☐ Yes ☐ No

If yes, please describe

_____

_____

Has your child ever had any previous counseling therapy? ☐ Yes ☐ No

If yes, please describe

Name	City, State	Duration (from mm/yyyy to mm/yyyy)	Reason

To the best of your knowledge, has your child had any thoughts of suicide? ☐ Yes ☐ No If yes, describe:

_____

_____

Has your child ever attempted suicide? ☐ Yes ☐ No If yes, describe:

_____

_____

Does your child have any history of physical abuse? ☐ Yes ☐ No If, yes describe:

_____

_____

Does your child have any history of violent behavior? ☐ Yes ☐ No If, yes describe:

_____

_____

Your assessment of your child's behavior

Please use complete the following using N = None, M = Mild and S = Severe to identify your child's recent behaviors.

	Sadness		Loneliness
	Crying		Indecisiveness
	Sleeping problems		Low self-worth
	Appetite changes (unusual)		Anger issues
	Unresolved guilt		Spiritual concerns
	Irritability		Drug or alcohol use
	Dishonesty		Abuse/neglect
	Social Anxiety		Trauma / flashbacks
	Self-harm		Problems at home
	Impulsive behaviors		Problems at school
	Mood Swings		Grief
	Isolation		Obsessive thoughts

Your Child's Strengths, Needs, Abilities and Preferences

What positive personal qualities would you say your child has?

_____

_____

What are some of your child's needs at this time?

_____

_____

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What are things your child does well?

_____

_____

What are things as a parent you'd like to work on?

_____

_____

When does your child/ or when do you prefer to have therapy? Check the best days.

Days	Daytime	Evening
Mondays		
Tuesdays		
Wednesdays		
Thursdays		
Fridays		
Saturdays		