

Southern Wake Counseling Center, PLLC

ADULT INTAKE FORM

(Please Print)

Today's Date ____/____/____

CLIENT INFORMATION

Client's Last Name	First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	

Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Mailing Address	City	State	ZIP Code	Social Security	Home Phone No. ()
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E-mail Address	Cell Phone No. ()
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Occupation	Employer	Employer Phone No. ()
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Chose CCS Because/Referred to CCS by (Please check one box) Dr. _____ Insurance Plan Hospital

Family Friend Close to Home/Work Yellow Pages Other _____

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO YOUR COUNSELOR)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
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Is this person a client here?	<input type="checkbox"/> Yes <input type="checkbox"/> No	()
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Occupation	Employer	Employer Address	Employer Phone No. ()
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Is this client covered by insurance? Yes No

Please indicate primary insurance _____

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
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Client's Relationship to Subscriber Self Spouse Child Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #
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Patient's Relationship to Subscriber Self Spouse Child Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No. ()	Work Phone No. ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the counselor when applicable. I understand that I am financially responsible for any balance. I also authorize Southern Wake Counseling center or my insurance company to release any information required to process my claims.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

History

1. Have you had prior counseling? If so, when and with whom?

2. Are you currently on any medications? If so, please list what they are and what you are using them for?

3. Describe your current use of alcohol/drugs.

4. Do you have a family history of mental illness or substance abuse? If so, please explain.

5. Have you ever been treated for substance abuse? If so, when, where, and for what substances?

6. Have you ever attempted suicide or had a plan to harm yourself? When?

7. Do you currently have any thoughts or feelings of wanting to physically harm yourself? If so, please describe your plan.

8. Have you ever been diagnosed with an eating disorder? If so, please describe.

9. Have you been sexually abused or do you worry that you might have been? _____

10. Briefly describe any medical history you feel is affecting your well being?

11. Has your eating and/or sleeping habits changed in the last 3 months? Please describe.

History Continued

12. Please describe your current academic/work functioning.

13. Please describe your social functioning.

14. What are your goals for counseling?

Symptoms List

Please check the box in front of any word or phrase you feel applies to you:

<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Naïve	<input type="checkbox"/>	Memory problems
<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	Unattractive	<input type="checkbox"/>	Nervous
<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	Fearful	<input type="checkbox"/>	Bored
<input type="checkbox"/>	Wanting to hurt self	<input type="checkbox"/>	Timid	<input type="checkbox"/>	Restless
<input type="checkbox"/>	Drug use	<input type="checkbox"/>	Poor concentration	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	Financial problems	<input type="checkbox"/>	Worthwhile	<input type="checkbox"/>	Empty feelings
<input type="checkbox"/>	Incompetent	<input type="checkbox"/>	Regrets for past	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Controlling	<input type="checkbox"/>	Misunderstood	<input type="checkbox"/>	Tense
<input type="checkbox"/>	Shy	<input type="checkbox"/>	Sympathetic	<input type="checkbox"/>	Poor academic performance
<input type="checkbox"/>	Don't take vacations	<input type="checkbox"/>	Intelligent	<input type="checkbox"/>	Worthless
<input type="checkbox"/>	Confused	<input type="checkbox"/>	Fainting spell	<input type="checkbox"/>	Stupid
<input type="checkbox"/>	Considerate	<input type="checkbox"/>	No appetite	<input type="checkbox"/>	Evil
<input type="checkbox"/>	Disabled	<input type="checkbox"/>	Regular alcohol use	<input type="checkbox"/>	Over ambitious
<input type="checkbox"/>	Not confident	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Good person
<input type="checkbox"/>	Cannot make decisions	<input type="checkbox"/>	Inadequate	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Few friends	<input type="checkbox"/>	Disturbing thoughts	<input type="checkbox"/>	Attractive
<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	Guilty	<input type="checkbox"/>	Lonely
<input type="checkbox"/>	Feelings of panic	<input type="checkbox"/>	Hateful	<input type="checkbox"/>	Not loved
<input type="checkbox"/>	Trembling	<input type="checkbox"/>	Inferior	<input type="checkbox"/>	Confident
<input type="checkbox"/>	Unable to relax	<input type="checkbox"/>	Bad home environment	<input type="checkbox"/>	Cannot keep a job

Please add any other information about you that would be helpful for the counselor to know.
