1911 Keller Andrews Road
Sanford, NC 27330
919.777.9355
www.wellcenteredcounseling.com

Adult Intake Form

Personal Information

Today's Date: _____

Last Name: _____First Name: _____M.I.:_____

Age: _____ Date of Birth: _____ Gender: _____

Street Address:

_____

City: _____ State: _____ Zip code: _____

Ok to send mail? _____ If no, please provide alternate address:

_____

EMAIL: _____

Home phone: _____ Ok to leave a message? _____

Cell phone: _____ Ok to leave a message? _____

Work phone: _____ Ok to leave a message? _____

Name of emergency contact: _____Relationship to you: _____

Address:_____

Home Phone: _____Cell/Work Phone: _____

Referral Source (how you heard about Well CENTERED):

_____

_____

Health Information

Please answer the following questions using: 5 -Excellent, 4 -Good, 3 - Average, 2 - Poor, 1 - Failing

How would you currently rate your physical health? _____

How would you currently rate your mental health? _____

How would you currently rate your spiritual health? _____ (if does not apply to you, please use N/A)

Please list current symptoms (reason you are here) and circle those you currently find most bothersome:

_____

_____

_____

_____

Medical Information

Do you now have, or have you had in the past, any of the following? Circle all that apply:

Asthma
Allergies Headaches
Brain Injury
Epilepsy /Seizures
Digestive Disorders
Cancer
Diabetes
Breathing Problems
Immune System Problems
Heart Disease
High Blood Pressure
Vision Problems
Hearing Problems
Arthritis
Urinary Disorders
Tuberculosis
Thyroid Disorder
Multiple Sclerosis
Chronic Fatigue Syndrome
Fibromyalgia
Pregnancy (how many)_____
Miscarriage (how many)_____
Abortion (how many)_____
Sexually Transmitted Disease
Sleep Disorder
Serious Accident
Surgery
Other

Are you currently under the care of a Doctor or other medical health professional? _____

Name of Primary Care Physician: _____ Physician Phone #: _____

Address:_____

Name of Specialist Physician: _____Physician Phone#: _____

Address: _____

Please list any prescription medications you are currently taking:

_____

_____

_____

Please list any over the counter medications, vitamins, or herbal supplements you are currently taking:

_____

_____

_____

Do you currently exercise? _____ If yes, please indicate how many times per week: _____

Please indicate substances currently used (over the past 6 months), how much at one time, how many times per day/week, age of first use, past use history, and length of time used.

Substance	Current	Amount	Frequency	Age	Past	Length
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Ecstasy						
Cocaine/Crack						
Heroin						
Methamphetamines						
PCP/LSD/Mushrooms						
Pain Killers						
Steroids						
Tranquilizers						
Sleeping Pills						
Diet Pills						

Have you ever believed your substance use was a problem for you?_____

Has anyone ever told you they believed your substance use was a problem?_____

Have you ever had withdrawal symptoms when trying to stop using any substances?_____

If yes, please describe:

_____

_____

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use?_____
If yes, please describe:

_____

_____

_____

Have you ever participated in drug and alcohol treatment? _____
If yes, please list type, length, dates, and age at time you received these services:

_____

_____

Do you currently or have you ever attended Alcoholics or Narcotics Anonymous? _____
If yes, please list length of time sober and number of meetings you attend per week:

_____

Mental Health Information

Have you ever been in counseling/therapy before? ____ If yes, did you find it helpful or effective? _____
Are you currently receiving mental health services? ____
If yes, please list name of practitioner and type of services you are receiving:

_____

_____

Have you ever been hospitalized for mental health concerns? ____ If yes, list date(s) and length of stay:

_____

_____

Have you ever been diagnosed with a mental illness? If yes, please list illness(es) and date(s) first diagnosed:

_____

_____

Has anyone in your family ever been diagnosed with a mental illness? If yes, please list relationship(s) and illness(es):

_____

_____

Have you ever or are you currently engaging in self harm? Currently: ____ Past: ____
Have you ever or are you currently contemplating suicide? Currently: ____ Past: ____
Have you ever or are you currently contemplating harming another person? Currently: ____ Past:____

Have you ever attempted suicide? _____

If yes please list date(s), method(s), and your age at time of attempt:

_____

_____

Has anyone in your family ever attempted suicide? ____ If yes please list relationship:_____

Has anyone in your family ever completed suicide? ____ If yes please list relationship:_____

Has anyone else in your life ever attempted ____ or completed suicide? ____

Relationship with that person: _____

Do you currently or have you ever had trouble sleeping? ____ If yes, please describe:

_____

_____

Do you currently or have you ever had problems with eating or with food? ____ If yes, please describe:

_____

_____

_____

Briefly describe why you are coming in for counseling and the goals you hope to achieve in therapy:

_____

_____

_____

_____

_____

Spiritual Information

Have you ever or do you currently engage in a personal faith practice: ____ If yes please describe:

_____

_____

Have you ever, or do you currently belong to a faith community (church, synagogue, temple, religious order, etc.? _____

If yes, please describe your current level of connection and involvement:

_____

_____

_____

Do you want to incorporate your faith/spirituality into the counseling process? ____
If yes, please describe how you would like to do so, and if you are specifically seeking spiritual guidance or direction:

_____

_____

_____

Relationship Information

Are you currently in a relationship? _____ If yes, please list status:_____
Name of Person: _____ Length of time you have known each other:_____
Length of time you have been together: _____Do you currently live together?_____
Number of marriages: _____ Number of divorces: _____ If widowed, your age at death of spouse:_____
Do you have children? _____ If yes, please list below:
Name_____ Age_____ Lives with you_____
Name_____ Age_____ Lives with you_____

If you are coming in for Couples or Family counseling, or are currently experiencing relationship difficulties you would like to address in individual counseling, please briefly describe:

_____

_____

_____

_____

Other persons living in your household and your relationship to them:

_____

_____

_____

Family Information

Were you adopted? _____ If yes, your age at time of adoption: _____
With whom did you live until the age of 18? _____

Did your parents ever divorce? _____ If yes, your age at time of divorce: _____
If divorced, did your parents ever re-marry? _____ If yes, list parent(s) and your age(s) at time of re-marriage:

_____

_____

Were you ever in foster care or residential care? ____ If yes, please list age and living situation:

_____

_____

Mother's current age: _____ If deceased, her age at death: _____ Your age at time of her death: _____

Father's current age: _____ If deceased, his age at death: _____ Your age at time of his death: _____

Do you have siblings? _____ If yes, please list names, ages, and relationship:

_____

_____

_____

Have you ever experienced the death of a family member or a close friend? _____

If yes please list relationship and your age at time of their death:

_____

_____

Please indicate if you or a member of your immediate family experienced any of the following.

If a family member, please indicate relationship(s):

Event	Self	Other	Relationship
Emotional Abuse			
Legal Problems			
Physical Abuse			
Frequent/Multiple Moves			
Sexual Abuse			
Homelessness			
Domestic Violence			
Accident or Injury			
Financial Problems			
Neglect			
Lived over-seas			
Substance Abuse			
Military member			
Serious Illness			
Discrimination			
Other			

Educational Information

Number of years of education completed: _____ Degree(s) achieved (please circle all that apply):

High School Diploma
G.E.D.
Vocational/Trade School Certificate
Associates Degree
Bachelors Degree
Master's Degree
Doctorate Degree
Other

Vocational Information

Are you currently employed? _____ If yes, please list position title, name of employer, type of work, and length of time at employment:

_____

_____

If you are not currently working, how long have you been un-employed?

_____

What types of jobs have you typically held?

_____

What is the longest period of time you have ever worked at one job?

_____

Are you currently considering a change in job or career? _____
If yes, what type of work are you interested in doing?

_____

_____

Have you ever served in the military? _____ If yes, please list branch, rank, and current status (active/discharged):

_____

If you have experienced a deployment, please list approximate dates and length of separation:

_____

_____

_____

_____

Please list your personal hobbies and interests:

_____

_____

_____

Legal Information

Have you ever been the victim of a crime?____ If yes, please list date and briefly describe:

_____

_____

_____

Are you currently involved in divorce or child custody proceedings? ____ If yes, please explain:

_____

_____

_____

Have you ever been convicted of a misdemeanor or felony? ____ If yes, please explain:

_____

_____

_____

Please detail any further information pertinent to your services at Well CENTERED:

_____

_____

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