Peak Vista Community Health Centers

Counseling Intake
Enrichment and Counseling Center (ECC)

Form # BH040 eng
Form Date: 07/12/24
Review By: 07/12/26

Today's Date: _____

Primary Patient Name: _____ Patient DOB: _____

Assigned Sex: _____ Gender Identity: _____

Primary language(s) spoken in home: _____

Briefly describe current difficulties: _____

_____

Family Data

Individuals in Home	Relationship	Age

ADULTS

Relationship Status: ☐ Single ☐ Common Law ☐ Married ☐ Separated ☐ Divorced ☐ Re-Married

MINORS

Custody Status*: ☐ Mother ☐ Father ☐ Other _____

**Provide copy of custody agreement as needed.*

Family Data

Name of Primary Care Clinic: _____

Name of Primary Care Provider: _____ Phone #: _____

Is patient currently prescribed any medications? ☐ No ☐ Yes

1. Name of medication: _____ Dosage: _____
   Prescribed & monitored by: _____ When started: _____
   For treatment of: _____

2. Name of medication: _____ Dosage: _____
   Prescribed & monitored by: _____ When started: _____
   For treatment of: _____

_____ _____

Signature of Individual Completing This Form Relationship to Patient