Enrichment & Counseling Center

Adult Intake

Form # BH 41 eng
Form Date: 08/03/20

Today's Date: _____

Patient Name: _____ Patient DOB: _____

Sex: _____ Gender Identity: _____ Sexual Orientation: _____

Presenting Problem

Describe your current difficulties: _____

_____

_____

When was the problem first noticed? _____

How did this problem come to your attention? _____

Who has tried to help with this problem? ☐ Family ☐ School ☐ Professionals ☐ Friends ☐ No one

What has been done to help the problem? _____

_____

What evaluation or treatment have you already received for the current problem or similar problems?

_____

Who provided the treatment and when was it? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Family Data

Relationship Status: ☐ Single Parent ☐ Common Law ☐ Married ☐ Seperated ☐ Divorced ☐ Re-married

Individuals in Home	Age	Relationship

Primary language(s) spoken in home: _____

Medical Status and History

Are you on any medication at this time? ☐ Yes ☐ No

Name of medication: _____ Dosage: _____

Prescribed & monitored by: _____ When started: _____

For treatment of: _____

Physical symptoms: Check any that you have experienced over the last month.

☐ headaches	☐ numbness	☐ chest pain
☐ dizziness	☐ tics/twitches	☐ nausea/stomach ache
☐ heart pounding	☐ fatigue	☐ choking sensations
☐ muscle tension	☐ fainting	☐ shortness of breath
☐ sexual problems	☐ blackouts	☐ trembling/shaking
☐ vision problems	☐ excessive sweating	

Please indicate any illness or condition that you have ever had:

Illness/Condition	Age
serious illness	
operations	
hospitalizations	
head injury	
freq. headaches	

Illness/Condition	Age
visual problems	
hearing problems	
allergies	
memory problems	
concentration difficulty	

Illness/Condition	Age
academic difficulty	
purge/restrict/overeat	
anxiety	
severe moods	
suicide attempt	

Family Medical History

Illness/Condition	Relation
cancer	
diabetes	
heart trouble	
seizure/epilepsy	
alcoholism	
drug use	
depression	
nervousness	
anxiety	

Illness/Condition	Relation
psychological problems	
suicide attempt	
hyperactivity	
behavior problems	
attention problems	
learning difficulties	
speech problems	
other	

Educational and Work History

Highest academic level completed: _____ Year: _____

Are you currently employed? ☐ Yes ☐ No

Current employment: _____ How long? _____

Social and Behavioral History

Have you ever been in trouble with the law? ☐ No ☐ Yes

Have you been verbally abused? ☐ No ☐ Yes ☐ Suspected

Have you been physically abused? ☐ No ☐ Yes ☐ Suspected

Have you been sexually abused? ☐ No ☐ Yes ☐ Suspected

Have you experienced other significant trauma? ☐ No ☐ Yes ☐ Suspected

Do you smoke or chew? ☐ No ☐ Yes ☐ Historically

How many caffeinated drinks do you have a day? _____

How often do you exercise? _____

Satisfaction: Rate on a scale of 1-10 (low to high)

How satisfied are you with the quality of your life? _____

How satisfied are you with your current family life? _____

How satisfied are you with the support you receive from your family and friends? _____

Are you able to enjoy your leisure time enough currently? ☐ No ☐ Yes

Favorite activities: _____

_____

Activities you would like to engage in more often than you do currently? _____

_____

Least favorite activites? _____

_____

_____

What are your assests or strengths? _____

_____

_____

_____ _____

Patient Signature Date completed