Eugene Pediatric
ASSOCIATES

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# Health Intake Form

Today's date: ________________________ PCP: ____________________________________________
Patients name: ________________________ Referring provider: _________________________________
DOB: _______________________________ Insurance: ______________________________________
Form completed by: ___________________ Relation: ___________________ Phone #: _______________
Education
Self: _______________________________ Partner: ______________________________________
Occupation
Self: _______________________________ Partner: ______________________________________
Client's Employer:
Emergency Contact: ___________________ Phone: ______________________________________

## General Health and Mental Health Information

How would you rate your current physical health?

- ☐ Poor
- ☐ Satisfactory
- ☐ Very good
- ☐ Unsatisfactory
- ☐ Good

Please list any specific health problems you are currently experiencing:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

How would you rate your current sleeping habits?

- ☐ Poor
- ☐ Satisfactory
- ☐ Very good
- ☐ Unsatisfactory
- ☐ Good

Please list any specific sleep problems you are currently experiencing:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

How many times per week do you generally exercise? ________________________________________
What types of exercise to you participate in: ______________________________________________
________________________________________________________________________________

Please list any difficulties you experience with your appetite or eating patterns.

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Are you currently experiencing overwhelming sadness, grief or depression? ____________________
For approximately how long? ____________________

Are you currently experiencing anxiety, panic attacks or have any phobias? ____________________
If yes, when did you being experiencing this? ____________________
____________________

Are you currently experiencing any chronic pain? ____________________
If yes, please describe. ____________________
____________________

Do you drink alcohol more than once a week?
☐ No ☐ Yes

How often do you engage recreational drug use?
☐ Daily ☐ Monthly ☐ Never
☐ Weekly ☐ Infrequently

Are you currently in a romantic relationship?
☐ No ☐ Yes
If yes, for how long? ____________________
How would you rate your relationship? ____________________

Do you have any history of violent behavior?
☐ No ☐ Yes
If yes, please describe: ____________________
____________________
____________________

**Additional information**

Do you enjoy your work? Is there anything stressful about your current work?
____________________
____________________
____________________

Do you consider yourself to be spiritual or religious?
☐ No ☐ Yes

What do you consider to be some of your strengths?
____________________
____________________
____________________
____________________

What do you consider to be some of your weakness?
____________________
____________________
____________________
____________________

____________________
Signature

Form last updated December 1, 2021

**Current Behaviors (past 30 days)** Please check all that apply.

- ☐ Threats of killing or hurting self
- ☐ Threats of killing someone else
- ☐ Hear or see things others do not
- ☐ Self-injury
- ☐ Fire setting
- ☐ Bed wetting
- ☐ Stealing
- ☐ Argumentative
- ☐ Avoidance of responsibility
- ☐ Secretive
- ☐ Irritable
- ☐ Racing thoughts
- ☐ Over-tired/easily fatigued
- ☐ Eating problems
- ☐ Oppositional behavior
- ☐ Hurting animals
- ☐ Unable to keep friends
- ☐ Day wetting
- ☐ Worries
- ☐ Tearful
- ☐ Angry mood
- ☐ Vandalism
- ☐ Lying
- ☐ Frequent physical complaints
- ☐ Nightmares
- ☐ ”Flash-Backs”
- ☐ Blames others
- ☐ Sexual acting-out
- ☐ Repetitive behaviors
- ☐ Hyperactivity
- ☐ Exaggerated sense of worth
- ☐ Hopelessness
- ☐ Drug/alcohol abuse
- ☐ Mood swings
- ☐ Frequent conflict
- ☐ Fearful
- ☐ Poor decisions
- ☐ Sad
- ☐ Delinquency
- ☐ Extreme shyness
- ☐ Recurring thoughts
- ☐ Hard to remember things
- ☐ Difficulty with concentrating
- ☐ Social isolation
- ☐ Panic attacks
- ☐ Crisis situation
- ☐ ED visit
- ☐ Use of crisis services
- ☐ Suicidal ideation
- ☐ Suicide attempt
- ☐ Difficulty sleeping
- ☐ Exposure to traumatic event:
  Example(s): ______________
  ____________________________
  ____________________________
  ____________________________

**Developmental History** Please check all that apply.

- ☐ Difficulties/abnormalities during pregnancy
- ☐ Medication during pregnancy
- ☐ Walking/gross motor difficulties
- ☐ Difficulties during pregnancy
- ☐ Excessive fears
- ☐ Difficult to comfort
- ☐ Exposure to drugs or alcohol during pregnancy
- ☐ Speech/Language problems
- ☐ Eating non-foods
- ☐ Fine motor problems
- ☐ Overly friendly
- ☐ Exposure to lead
- ☐ Poor attachment to parents/caregivers
- ☐ Problems eating as a baby
- ☐ Problems sleeping as a baby
- ☐ Away from parents for a long time
- ☐ Premature at birth
- ☐ Underweight at birth
- ☐ Did not meet developmental milestones on time
- ☐ Neglect

**Experiential History** Please indicate what you have experienced in life until now.

- ☐ Death in the family
- ☐ Crime victim
- ☐ Violence in home
- ☐ Parental illness
- ☐ Emotional abuse
- ☐ Parental divorce
- ☐ Parental/guardian separation
- ☐ Police confrontation
- ☐ Witness to drug abuse
- ☐ Witness to domestic violence
- ☐ Fights at school
- ☐ Poor grades
- ☐ Good grades
- ☐ Other academic concerns

- ☐ Alcohol/drug abuse (by whom and when) ____________________________________________
- ☐ Sexual or physical abuse (by whom and when) ________________________________________
- ☐ Known family history of physical or sexual abuse (by whom and when) ________________________
- ☐ DHS involvement ____________________________________________________________

________________________________________
Signature

Please tell us about your family history and current family situation.

Who is in the home? If multiple homes, please list all members in all households.

Tell us about events that have happened in your life that may impact how you function now.

Please give a detailed description of the current situation and the reasons you are seeking support.

Do you have specific characteristics that you are looking for in a therapist? (Personality, gender identification, expertise, etc.)

Are you taking any medications, vitamins or supplements?

Have you attempted suicide in the last 30 days? If so, please explain.

Have you ever attempted suicide? If so, please explain.

Signature

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**<u>Overall family-life growing up is/was</u>** Please check all that apply.

- ☐ Supportive
- ☐ Loving
- ☐ Chaotic
- ☐ Confusing
- ☐ Affirming
- ☐ Strict
- ☐ Hostile
- ☐ Safe
- ☐ Unsafe
- ☐ Negative

Have you or any family member had counseling before? If yes, please list the dates, with whom, and for what purpose.

______________________________________________________________________________

______________________________________________________________________________

Have you ever been prescribed psychiatric medication?

- ☐ Yes
- ☐ No

Please list and provide dates: _______________________________________________________

______________________________________________________________________________

Has anyone in the family ever seriously considered or attempted suicide? If so, please explain whom, the circumstances, and when this took place.

______________________________________________________________________________

______________________________________________________________________________

**<u>Please read and initial the following:</u>**

_____ I understand I may be referred to Specialty Services, should I need a higher level of care.
_____ I understand that my counselor IS NOT available for crisis intervention or emergencies.
_____ In case of an emergency, please call 911.
_____ If suicidal, please go to the Emergency Room.

**Please list 3 goals:**

1. ____________________________________________________________________________

______________________________________________________________________________

2. ____________________________________________________________________________

______________________________________________________________________________

3. ____________________________________________________________________________

______________________________________________________________________________

What is the best way to reach you if we need to?

Phone or email? (Circle one and please list best phone number or email address below.)

________________________________________

Signature

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