WHITE OAK Counseling and Recovery
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LENS Intake Form

Name: _____ Date: _____

Most prominent problems being experienced:

_____
_____
_____
_____
_____

Been experiencing how long?

_____
_____

How were you before these problems occurred (if relevant)?

_____
_____
_____
_____

Previous symptoms throughout your entire life:

_____
_____
_____
_____

Current medication Reasons for taking Effects on you

_____
_____
_____
_____
_____
_____

Basis for incomplete Problem Resolution:

		Past	Present
1.	Unpredictable things had a big effect on me.	☐ Y ☐ N	☐ Y ☐ N
2.	Situations were/are embarrassing for me.	☐ Y ☐ N	☐ Y ☐ N
3.	Friends and/or family had/have a hard time being around me.	☐ Y ☐ N	☐ Y ☐ N
4.	I was/am troubled by emotions/feelings.	☐ Y ☐ N	☐ Y ☐ N
5.	I had/have problems like seizures, tics, migraines, headaches, cluster headaches, stuttering, Tourette's, explosiveness.	☐ Y ☐ N	☐ Y ☐ N

How much time and money have you spent on your primary problem:

_____

_____

_____

_____

How will you know when you are done?

_____

_____

_____

_____