Cognitive Health Solutions LLC

Main Office (Hanover):
100 West Eisenhower Drive, Suite A
Hanover, PA 17331
Phone: (717) 632-8400
Fax: (717) 632-9300

York Office:
2500 Kingston Road, Suite 1
York, PA 17402
Phone: (717) 747-3659
Fax: (717) 885-5550

Chambersburg Office:
550 Cleveland Avenue, Suite 101
Chambersburg, PA 17201
Phone: (717) 446-0232
Fax: (717) 632-9300

Adult Intake History Form

Patient Name:		**Date of Birth:**	**Today's Date:**
Marital Status:	☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Other:		**Gender:** ☐ Male ☐ Female
Address:	Street:		
	City	State	Zip
Phone Numbers (put only those we may call, and identify them as needed. Example: "mom's cell"):			
Home:		Mobile:	
Work:		Alternate:	
Employment :	☐ Employed ☐ Unemployed ☐ Full Time Student: Grade: _____ ☐ Part Time Student: Grade: _____		
If in school, what is the school name?			
Email Address (only provide if you are giving permission for us to email you):			
How would you like to receive appointment reminders?	☐ Email	☐ Call	☐ Text ☐ None, thank you.
Emergency Contact:	**Phone Number:**		**Relationship:**
Address (if different):			

Insurance Information: If you plan to use insurance for payment this information is needed to bill insurance company.

Insurance Company Name:		**Policyholder's name:**
Insurance ID #:		**Group #:**
Relationship to Patient:	**Policyholder DOB:**	**Employer:**

***If the patient is covered under a secondary insurance policy please discuss this with the office staff.**

History of Present Problem

Describe your main concerns or problems (symptoms, duration, frequency):

Describe the reason you are seeking treatment at this time:

List any services or interventions you would like to receive and any goals you hope to achieve with treatment:

Past Psychiatric History

Have you received any of the following mental health or behavioral services before?

☐ Inpatient hospitalization	☐ Partial hospitalization
☐ Outpatient services	☐ Wraparound services
☐ Family-based mental health	☐ Residential treatment facility
☐ Drug and alcohol treatment	☐ MH/MR case management
☐ Medication prescription/management	☐ AA/NA attendance

☐ Other (explain):

Have you been given a prior diagnosis? If so, explain:

Trauma History

Have you ever experienced abuse or a trauma? Briefly explain:

Family Psychiatric History

Please note any family history of learning, developmental, attention, behavior, emotion, mental, or medical problems:

List agencies/caseworkers/clinicians currently working with you/your family on the problems noted above, if any:

Medical Conditions & History

How is your overall health?	☐ Poor	☐ Fair	☐ Good	☐ Excellent

Please list any current or past health concerns (ex. Asthma, high fever, major surgery, hospitalization):

Approximate date of last physical examination: _____ Where/By Whom?	Have you suffered any head injuries? ☐ Yes ☐ No If yes, when?
List any allergies:	

Substance Use

Do you currently drink alcohol?	☐ Yes ☐ No	How often?	☐ Rarely ☐ 1-2 days/wk ☐ 3-6 days/wk ☐ Daily
Do you use any drugs (ex. nicotine, caffeine, cannabis)?	☐ Yes ☐ No	What, how much, and how often?	
Have you used any drugs in the past?	☐ Yes ☐ No	What, and when?	

Family History

Check all that best describe your current living situation:

☐ Alone	☐ With Spouse/Family	☐ With Parents/Family	☐ With Significant Other
☐ Apartment	☐ House	☐ Homeless/Shelter	☐ Other:

Primary language spoken at home:			
Is a second language spoken at home? What?		Fluency: ☐ Fluent ☐ Limited ☐ None	
Any major stresses in the family that have affected you (ex. death, divorce, etc.)?			

List the names and information for all individuals living in the household (include caregivers, children, roommates, etc.):

Name	Age	Relationship	Comments/Concerns

Do you have children living outside your home? ☐ Yes ☐ No	If yes, list names, ages, and relationship:

Social History

Did you have problems getting along with other children as a child?	☐ Yes ☐ No
Do you have difficulty making and keeping friends?	☐ Yes ☐ No
Do you find being in a social situation difficult?	☐ Yes ☐ No
Do you have any current social or relationship concerns?	☐ Yes ☐ No

If you checked yes for any of the above questions, explain your response:

Developmental History

Were there any difficulties with your mother's pregnancy? ☐ Yes ☐ No	Explain:
Were there any notable developmental delays in your childhood? ☐ Yes ☐ No	Explain:

Education and Occupational History

List the **most recent school** the patient has attended:

School & Location (City, State)	Highest Grade level or Degree completed	Comments/Problems

Did you *ever* repeat or skip a grade? ☐ Yes ☐ No	Explain:
Were you ever evaluated for special education services in school? ☐ Yes ☐ No	Explain:
Describe your academic and behavioral strengths and weaknesses in school:	

Provide information on your job history, beginning with the most recent:

Employer	Dates of Employment	Job Title	Reason for Leaving

Have you ever been fired or let go from an employment position? ☐ Yes ☐ No	Explain:

Legal History

Were you ever arrested or have you had legal charges filed against you?	☐ Yes ☐ No	Explain:
Are you currently on probation or parole?	☐ Yes ☐ No	Explain:

Strengths/Limitations and Other Information

Strengths/Limitations:
Provide information on your interests/dislikes:
Write any additional comments that may assist in your evaluation and therapy:

Medications

Are you currently taking any medications? ☐ Yes ☐ No ☐ I do not wish to disclose

Medication (Please include ALL taken including over-the-counter, vitamins, nutritional supplements, etc.)	**Dosage/Frequency**	**Route of Administration** (oral, injection, liquid, etc.)	**Managing Physician**