



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:

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

Past		Present	
<input type="checkbox"/>	Y <input type="checkbox"/> N	<input type="checkbox"/>	Y <input type="checkbox"/> N
<input type="checkbox"/>	Y <input type="checkbox"/> N	<input type="checkbox"/>	Y <input type="checkbox"/> N
<input type="checkbox"/>	Y <input type="checkbox"/> N	<input type="checkbox"/>	Y <input type="checkbox"/> N
<input type="checkbox"/>	Y <input type="checkbox"/> N	<input type="checkbox"/>	Y <input type="checkbox"/> N
<input type="checkbox"/>	Y <input type="checkbox"/> N	<input type="checkbox"/>	Y <input type="checkbox"/> N

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

How will you know when you are done?
