Neuro therapeutic
Pediatric Therapies Inc

Confidential Information and History-Adult

All information disclosed to Neurotherapeutic Pediatric Therapies' staff is confidential, except when a person is in danger of abuse or suicide, is a clear and present danger to their-self or others or is the victim of a crime. An authorization for release of information must be signed before information can be given to the court, school, or third party in any other case not mentioned above. ***Please complete this form as applicable.***

Today's Date ________________________

CLIENT INFORMATION

Legal First Name: _______________________________ Legal Last Name: ____

Preferred Name: _______________________________________ DOB *(mm/dd/yyyy)*: ____________________

Marital Status: ❒ SINGLE ❒ MARRIED ❒ DIVORCED ❒ SEPARATED ❒ WIDOWED ❒ DOMESTIC PARTNERS

❒ NEVER MARRIED ❒ OTHER ____

WORK HISTORY

Are you currently employed? ❒ No ❒ Yes,

If yes is it: ❒ Full time *(30 or more hours)* ❒ Part-time *(less than 30 hours)*

❒ Odd Jobs/Temporary ❒ Training Program

What kind of work do you do? ____

CURRENT PROBLEMS

Please describe briefly what changes you are hoping to make by starting services now.

Please mark only the symptoms below which you have experienced in the past 3 months.

___Relationship Issues	___Computer addiction	___Recurring, intrusive thoughts/memories
___Depression	___Feeling hopeless	___ Problems with pornography
___Obsessions or compulsions	___ Parenting issues	___Change in sleeping habits
___Trouble concentrating	___Extreme sadness/crying spells	___Change in eating habits
___Memory problems/confusion	___Lack of energy	___Feelings of extreme happiness/excessive energy
___Weight changes	___Feeling stressed	___Change in sexual interest or function
___Self-esteem problems	___Feeling guilty	___Problems getting along w/others
___Anger/irritability	___Feeling fearful	___Trouble performing your job
___Feeling anxious	___Acting violently	___Lack of enjoyment of usual activities
___Lack of motivation	___ Fatigued	___Sudden feelings of panic
___Physical complaints of pain	___Thoughts of/attempts to hurt yourself/others	___Thoughts of killing yourself/others
___Social discomfort	___Muscle tension	___Flashbacks
___Hearing voices	___Visual hallucinations	___Suspicion/paranoia
___Racing thoughts	___Wide mood swings	___Nightmares
___Gambling problems	___Other: ____	

Have you ever thought of/attempted to hurt yourself/others? ❒ No ❒ Yes If yes, explain:

____

Have you ever thought of/attempted suicide? ❒ No ❒ Yes If yes, explain:

____

Have you ever been diagnosed or treated for an eating disorder? ❒ No ❒ Yes If yes, explain:

____

SOCIAL

Spiritual? Religious? Church/Spiritual Community? ❒ No ❒ Yes If yes, how important is it?

____

Do you have social support? ❒ FAMILY ❒ NEIGHBOR ❒ FRIENDS ❒ CO-WORKERS ❒ OTHER: ______________________________

If so, who?

What are the hobbies/activities that you find pleasure in?

MEDICAL INFORMATION

Past/current medical problems/surgeries:

Were developmental milestones met appropriately (i.e., sitting up as infant, walking, talking on time with average child development)? Yes No If no, please describe:

Preferred Pharmacy: ____

Within the past 12 months, have you worried whether your food would run out before you got money to buy more?

No Yes

Within the past 12 months, have you thought that the food you bought just didn't last and you didn't have money to buy more? No Yes

Are you sexually active? ❒ No ❒ Yes

Have you ever been pregnant? ❒ No ❒ Yes

Do you have any children? ❒ No ❒ Yes

If Applicable:

Any problems with menses? ❒ No ❒ Yes Date of last menstrual period? ____________________________________

PREVIOUS MENTAL HEALTH TREATMENT

Outpatient: ❒ No ❒ Yes **Inpatient** ❒ No ❒ Yes
Drug/Alcohol: ❒ No ❒ Yes **Group:** ❒ No ❒ Yes
Have you or your family ever attended therapy/counseling before? ❒ No ❒ Yes If yes, please describe below:

1. **Name of therapist/counselor/agency** ______________________________

   Did you go alone or with your family? ______________________________Dates: ____________________

   Reason: ______________________________

2. **Name of therapist/counselor/agency** ______________________________

   Did you go alone or with your family? ______________________________Dates: ____________________

   Reason: ______________________________

FAMILY MENTAL HEALTH HISTORY

Describe any mental health issues within your immediate family:

____

Are any of your family members frequent drug or alcohol users? ❒ No ❒ Yes, If yes, which members?

____

SUBSTANCE USE HISTORY

Have you, or are you currently using drugs or alcohol? ❒ No ❒ Yes

If yes, at what age did you begin drinking alcohol? ______________________________

If yes, at what age did you begin using drugs? ______________________________

What types of drugs (including alcohol) have you or are you presently using?

____

Frequency/quantity of alcohol consumption ______________________________

How many drinks does it take for you to feel drunk? ______________________________

Have you ever experienced a memory loss during drinking? ______________________________

Have you ever overdosed from drugs/alcohol? ______________________________

Quantity of cigarette smoking ______________________________

Amount of caffeine consumption ______________________________

Please indicate if any of the below apply. If possible, also include dates. If not applicable, please indicate "N/A".

Drug/Alcohol Withdrawal: ______________________________

Intravenous Drug Use: ______________________________

LEGAL HISTORY

Ever been convicted of a misdemeanor or felony? ❒ No ❒ Yes If yes, explain:

____

Please list any previous charges or arrests (include runaway, curfew violation, MIP, etc.):

____

Number of arrests/charges in the last 24 months: _______________

Have any of these charges been drug/alcohol related? ____

Are you currently involved in divorce or child custody proceedings? ❒ No ❒ Yes **Previously?** ❒ No ❒ Yes

If yes, please explain: ____

Is DHS Involved? ❒ No ❒ Yes **If yes, why?**

____

Are you court ordered to attend Mental Health Treatment? ❒ No ❒ Yes