

NeuroHealth Associates, LLP  
1942 NW Kearney Street  
Portland, Oregon 97209

**CLIENT INFORMATION**

**IDENTIFYING INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Telephone(s): (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Other) \_\_\_\_\_

May I leave messages for you at home? \_\_\_\_\_ May I leave messages at work? \_\_\_\_\_ E-mail \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ SS# \_\_\_\_\_ Referred by: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Partner (if any): \_\_\_\_\_

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Military Veteran Status: \_\_\_\_\_

Spouse/Partner Occupation: \_\_\_\_\_ Spouse/Partner work phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone(s): \_\_\_\_\_

Relationship to Emergency contact: \_\_\_\_\_

Parent/Guardian (if under 18): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Members' Names	Relationship	Age	Occupation/School	Lives with you?
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe the primary problem(s) for which you are seeking therapy at this time:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client's Name: \_\_\_\_\_

Please circle any of the symptoms that you are having or have had recently:

- |                                 |                                     |                               |   |
|---------------------------------|-------------------------------------|-------------------------------|---|
| Depression                      | Feeling hopeless                    | Trouble concentrating         | Memory problems                           |
| Change in sleeping habits       | Change in eating habits             | Weight changes                | Trouble performing your job               |
| Lack of energy                  | Changes in sexual interest/pleasure | Feeling nervous               | Sudden feelings of panic                  |
| Muscle tension                  | Obsessions or compulsions           | Perfectionism                 | Self-esteem problems                      |
| Easily irritated                | Feeling stressed                    | Flashbacks/Intrusive memories | Problems getting along with family/others |
| Thoughts about hurting yourself | Thoughts about hurting others       | Thoughts about killing others | Physical pain                             |
| Thoughts about killing yourself | Problems with anger                 | Acting violently              |   |

Please add useful details: \_\_\_\_\_

PREVIOUS MENTAL HEALTH TREATMENT

<u>Name of Provider</u>	<u>Dates of Treatment</u>	<u>Reason for Treatment</u>	<u>Outcome</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL INFORMATION

Your Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list current medical conditions/allergies:

- 1.
- 2.
- 3.

Current Medications:

<u>Name</u>	<u>Dose/Day</u>	<u>Condition Treated</u>	<u>Who Prescribing</u>	<u>How long have you taken this?</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Client's Name: \_\_\_\_\_

Indicate problems or conditions you have currently (C) or have had in the past (P):

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Eye, ear, nose, throat | <input type="checkbox"/> Diabetes           |   |
| <input type="checkbox"/> Faintness         | <input type="checkbox"/> Skin                   | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Prostate problem |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Genital                | <input type="checkbox"/> Heart disease      | <input type="checkbox"/> Rheumatic fever  |
| <input type="checkbox"/> Sleep problems    | <input type="checkbox"/> AIDS                   | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Scarlet fever    |
| <input type="checkbox"/> Muscle/joint/bone | <input type="checkbox"/> Alcoholism             | <input type="checkbox"/> High cholesterol   | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Weakness          | <input type="checkbox"/> Appendicitis           | <input type="checkbox"/> HIV positive       | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Numbness          | <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Kidney disease     | <input type="checkbox"/> Tonsils          |
| <input type="checkbox"/> Urinary           | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Measles            | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Stomach/bowel     | <input type="checkbox"/> Chemical dependence    | <input type="checkbox"/> Multiple sclerosis |   |
| <input type="checkbox"/> Venereal disease  | <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Chicken pox        | <input type="checkbox"/> Mumps            |

When was your last complete physical exam? \_\_\_\_\_

Please list any major hospitalizations, dates and condition treated: \_\_\_\_\_

#### SUBSTANCE USE HISTORY

Please check if you currently use the following substances: Alcohol \_\_\_\_\_ amount \_\_\_\_\_; Tobacco/cigarettes \_\_\_\_\_ amount \_\_\_\_\_; Caffeine (includes coffee, colas etc.) amount \_\_\_\_\_; Marijuana \_\_\_\_\_ amount \_\_\_\_\_; Cocaine \_\_\_\_\_; Sleeping pills \_\_\_\_\_; Tranquilizers \_\_\_\_\_; Pain killers \_\_\_\_\_; Mushrooms \_\_\_\_\_; Crank/crack \_\_\_\_\_; LSD/Psychedelics \_\_\_\_\_; Amphetamines \_\_\_\_\_; Inhalants \_\_\_\_\_; Over-the-Counter meds (specify) \_\_\_\_\_ Other herbs or drugs: \_\_\_\_\_

Do you now use or have you in the past had a problem with your use any of the these substances, such as excessive use, difficulty cutting down, feeling dependent on them? If so, please explain:

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Please list any past or current substance abuse treatment (specify dates):

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