NeuroHealth Associates LLP

1942 NW Kearney Street Portland, Oregon 97209
503-221-7074

IDENTIFYING INFORMATION

Name_____ **Date**_____

Address_____ **City/State/Zip**_____

Telephone_____ **(Work)**_____**(Other)**_____

Email_____

May a message be left for you on your phone? _____ at work? _____ on your email?_____

Age_____ **Birthdate**____/____/____ **Referred by**_____

Marital Status_____ **Partner Name**_____

Education_____ **Occupation**_____

Employer_____

Spouse/Partner Occupation_____**Spouse/Partner Work Phone**_____

Emergency Contact_____

Relationship to Emergency Contact_____

Parent/Guardian (if under 18)_____

Address_____**Phone**_____

Family Member Name	Relationship	Age	Occupation/School	Lives with you?

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

PREVIOUS MENTAL HEALTH TREATMENT

Name of Provider **Dates of Treatment** **Reason for Treatment** **Outcome**

_____

_____

_____

MEDICAL INFORMATION

Primary Physician_____ **Phone**_____

Please list current medical conditions/allergies:

1._____ **2.**_____

3._____ **4.**_____

CURRENT MEDICATIONS

Name **Dose/Day** **Condition Treating** **Who Prescribes** **Length on medication?**

_____

_____

_____

Client's Name_____

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

____Headache	____Skin	____High cholesterol
____Faintness	____Aids	____HIV positive
____Dizziness	____Alcoholism	____Kidney disease
____Sleep problems	____Appendicitis	____Measles
____Muscle/joint/bone	____Arthritis	____Chicken pox
____Weakness	____Asthma	____Diabetes
____Numbness	____Chemical dependence	____Prostrate problems
____Urinary	____Chest pain	____Rheumatic fever
____Stomach/bowl	____Epilepsy	____Scarlet fever
____Venereal disease	____Heart disease	____Stroke
____Eye/ear/nose/throat	____Hepatitis	____Thyroid problems
____Tonsils	____Multiple sclerosis	
____Ulcers	____Mumps	

When was your last complete physical?_____

Please list any major hospitalizations, dates, and conditions treated_____

_____

_____

SUBSTANCE USE HISTORY

Please indicate if you currently use or have used in the past the following substances:

	Past	Current	Amount		Past	Current	Amount
Tobacco/cigarettes				Cocaine			
Alcohol				Mushrooms			
Caffeine (incl. coffee/colas/etc)				LSD Psychedelics			
Marijuana				Sleeping pills			
Tranquilizers				Crank/crack			
Pain killers				Amphetamines			
Over-The-Counter meds				Inhalants			

Client's Name_____

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

_____

_____

_____

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

_____

_____

_____

FAMILY PSYCHIATRIC/SUBSTANCE ABUSE HISTORY

Please describe any family members psychiatric problems and/or alcoholism or other substance abuse problem, including what you know about any treatment that was received for the problem:_____

_____

_____

_____

Other information which you would like to include on this form:_____

_____

_____

_____

Thank You For Taking The Time To Complete This Questionaire