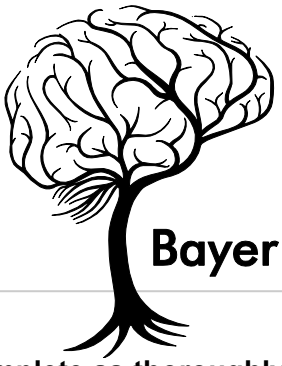

Bayer NeuroBehavioral Center, PLLC

Please complete as thoroughly as possible. **Today's Date:** _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Date of Birth: _____ Age: _____ Race: _____

Home/Cell Phone: _____ Other Phone: _____

Marital Status: _____ Spouse/Partner's name: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

REASONS FOR REFERRAL

What are your concerns and reasons for seeking therapy? _____

_____

_____

Please list what you consider to be the top three stressors in your life:

1. _____ 2. _____ 3. _____

CURRENT SYMTPOMS *Check all that you have experienced in the **last month**.*

☐ Headaches	☐ Concentration Problems	☐ Sexual problems
☐ Difficulty with Sleep	☐ Impulsivity	☐ Problems making decisions
☐ Pain	☐ Irritability	☐ Difficulty communicating
☐ Dizziness	☐ Anger	☐ Racing thoughts
☐ Vision Difficulties	☐ Depression	☐ Muscle Tension
☐ Light Sensitivity	☐ Anxiety	☐ Paranoia
☐ Hearing Difficulties	☐ Suicidal Thoughts	☐ Blackouts
☐ Balance Problems	☐ Change in appetite	☐ Substance use problems
☐ Memory Problems	☐ Fatigue	☐ Other_____

Symptoms interfere with ☐ work ☐ home ☐ school ☐ relationships ☐ leisure

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What do you believe to be the cause of your current problems?

_____

_____

MENTAL HEALTH TREATMENT HISTORY

Have you ever been **hospitalized for mental or emotional problems**? **YES / NO**

Have you ever been prescribed medication for mood or behavior (depression, anxiety, ADD/ADHD? **YES / NO** *If YES, describe*: _____

Please list current and past mental health providers below (please attach sheet if needed)

Name of Dr. or provider	Specialty (Psychiatrist, Psychologist, counselor, etc)	Reason for Visits	Approximate dates

CURRENT MEDICATIONS

Please list all medications you currently take, including medical or psychiatric prescription medications, over the counter, herbal and/or exercise supplements.

Please include dosage of medications if known.

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY

List your current physicians

Name	Specialty (Primary Care, Neurology, etc)	Phone Number

Date of **last medical examination** _____

Please indicate if you have had **any history** of the following:

☐ Alcoholism/ Addiction	☐ Gastrointestinal disorder	☐ Respiratory problems
☐ Anoxia or hypoxia	☐ Genital or urinary problems	☐ Sleep apnea
☐ Anxiety	☐ Headaches	☐ Stroke
☐ Arteriosclerosis	☐ Head Trauma	☐ Schizophrenia
☐ Arthritis	☐ Heart disease	☐ Suicide attempts
☐ Attention Deficit/Hyperactivity	☐ HIV	☐ Syncope
☐ Alzheimer's disease	☐ Huntington's chorea	☐ Syphillis
☐ Bipolar Disorder	☐ Hypertension/high blood press.	☐ Systemic lupus erythematous
☐ Cancer	☐ Hypoglycemia	☐ Thyroid (hypo/hyper) disease
☐ Cerebral vascular disease	☐ Hypernatremia	☐ Toxic or heavy metal exposure
☐ Cortisol deficiency	☐ Liver Disease	☐ Tumor
☐ Dementia	☐ Motor Difficulties	☐ Vertigo
☐ Depression	☐ Parkinson's disease	☐ Vitamin deficiencies
☐ Diabetes	☐ Pernicious (B12) Anemia	☐ Other _____
☐ Epilepsy	☐ Renal dialysis	☐ Other _____

Have you ever had a **seizure**? **YES / NO** Date of last seizure: _____

Have you had any surgeries? **YES / NO** *If YES, what/when:* _____

_____

Do you have any **pending surgeries** or procedures? **YES / NO** *If YES*, explain: ____

_____

Do you have **pain**? **YES / NO** Where/what kind?_____

Are you being seen by a provider for this pain? **YES / NO** Who: _____

Do you use **tobacco** products? **YES / NO** Amount: _____

Do you use **caffeine**? **YES / NO** Amount: _____

Do you exercise? **YES / NO** How many times each week: _____

Current **height**: _____ Current **weight:** _____ Recent weight change? **YES / NO**

If YES, how much have you lost or gained (*circle which)*?_____

Do you vomit or use laxatives to maintain/lose weight. **YES / NO**

Do you have times when your eating is out of control **YES / NO**

SUBSTANCE USE HISTORY

Substance	Have you used in last month?	How often in **last month**	How much do you use each time?	Have you used in the past?	Dates of Heaviest Use	How often **during heaviest period**	How much did you use during this period?
Alcohol	Y N			Y N			
Marijuana	Y N			Y N			
Cocaine	Y N			Y N			
Opioids	Y N			Y N			
Other	Y N			Y N			

Have you ever had problems related to use of any substances? **YES / NO**

Were you ever referred for substance abuse treatment? **YES / NO**

Were you ever physically dependent on **prescription medication**? **YES / NO**

If YES, please describe: _____

FAMILY HISTORY

☐ Arthritis
☐ Cancer
☐ Diabetes
☐ Huntington's chorea
☐ Alzheimer's disease
☐ Epilepsy
☐ Heart disease
☐ Thyroid disorders
☐ Dementia
☐ Brain disease
☐ High blood pressure
☐ Parkinson's disease
☐ Stroke
☐ Depression
☐ Anxiety
☐ Alcoholism / Addiction
☐ Bipolar Disorder
☐ Schizophrenia
☐ Suicide or Attempts
Other _____

DEVELOPMENTAL HISTORY

Where were you born? _____

Were you adopted? **YES / NO** *If YES*, at what age? _____

How many siblings (including ½ and step-siblings) did you have? Brothers: ____ Sisters: ____

Did you have any delays in developmental milestones? **YES / NO** / **Unknown**

Did you have any therapies? **YES / NO** Speech / Occupational / Physical / Other : _____

What was it like in your childhood home?

☐ loving ☐ comfortable ☐ chaotic ☐ abusive ☐ other _____

Who were you closest to? _____

Who disciplined in the home? _____ How? _____

Any childhood health problems, injuries, accidents? **YES / NO**

If YES, explain: _____

Any emotional or behavior problems as a child? **YES / NO**

If YES, explain: _____

Have you ever been a victim of abuse? **YES / NO** ☐ physical ☐ emotional ☐ sexual

Have you perpetrated abuse on anyone else? **YES / NO**

EDUCATION

Highest level of education: _____

Dates of enrollment	School	Grades / GPA	Degree earned or Reason for leaving

As a child, were you ever held back a grade? **YES / NO** Which: _____

Did you ever receive special education services? **YES / NO**

Were you ever in "gifted" or Advanced Placement classes? **YES / NO**

Were you ever suspended or expelled from school? **YES / NO**

EMPLOYMENT HISTORY

Are you currently employed? **YES / NO** Occupation: _____

Employer: _____ Time with employer: _____

How many jobs have you held?_____ What's the longest time you held the same job? _____

What's the shortest time you held a job? _____

Have you ever: a) Been fired? **YES / NO** b) Been laid off? **YES / NO** c) Quit a job without giving any notice? **YES / NO**

FAMILY / SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ In a relationship

If in a relationship, how long have you been together? _____

are you currently living with your spouse/partner? **YES / NO**

Rate your satisfaction with your relationship on a scale of 1 to 7 (poor to excellent):

Poor **1** **2** **3** **4** **5** **6** **7** Excellent

Are you having any current problems in your relationship that you would like help with?

_____

How many times have you been married: _____

Please list the names, ages and gender of any children you have:

Name	Age	Gender	Step/Biological	Currently lives with

Does anyone else reside in your household? *If YES*, please list names, ages, and relationship:

_____

Is there access to firearms in your home? **YES / NO**

Do you have someone you can talk to when you have a problem? **YES / NO**

If YES, who? _____

How many close friends do you have? _____

Do you live far from family and friends? **YES / NO**

Are you having trouble in your relationships with family and friends? **YES / NO**

Have you recently withdrawn from friends or family? **YES / NO**

Are you currently using any community resources or groups? (e.g., chaplain, ASAP, Social Work Services, AA meetings, etc.)? **YES / NO**

What are your hobbies?_____

Do you participate in any "high risk" hobbies (bungee jump, motorcycle, etc)? **YES / NO**

From 0 – 10, how satisfied are you with your social life? _____

FINANCIAL ASSESSMENT

Do you currently have any financial problems? **YES / NO**

If YES, please explain: _____

Please check sources of income in your household:

- ☐ Wages from Employment (before taxes)
- ☐ Public Assistance
- ☐ Social Security
- ☐ Disability Compensation
- ☐ Unemployment Compensation
- ☐ Alimony
- ☐ Child Support
- ☐ Monies from Relatives
- ☐ Interest from Investments
- ☐ Veteran's Benefits

LEGAL ASSESSMENT

Have you ever been arrested? **YES / NO**

Do you have any current legal difficulties / issues? **YES / NO**

If YES, please explain: _____

CULTURAL BACKGROUND

What is your racial / ethnic identification? _____

Is English your first language? **YES / NO** *If NO, list other languages:* _____

_____

What is your religious/spiritual affiliation, if any? _____

On a scale of 0-10, how important are your spiritual beliefs in your life? _____

Do your current difficulties affect your spirituality? **YES / NO**

Do you have any religious/spiritual practices I need to be aware of? **YES / NO**

If YES, please explain: _____

MILITARY HISTORY (if applicable)

Branch of Service: ☐ USA ☐ USAF ☐ USN ☐ USMC ☐ USCG

Dates of Service: _____

MOS: _____ Job Title: _____

Rank at Discharge: ____ Highest Rank (if different from rank at discharge): _____

Do you have any service connected disabilities? **YES / NO**

If YES, please list: _____

Deployments:

Location	Dates of deployment/ tour

Nature of discharge: ☐ Honorable ☐ General ☐ Other than honorable

Have you ever had a disciplinary action? **YES / NO**

___Article 15 ___Court Martial ___Letter of Reprimand ___Counseling Statement

____Chapter

How satisfied were you with your military job?

Very Unsatisfied Unsatisfied Satisfied Very Satisfied

GOALS FOR TREATMENT

What are your goals for treatment? In other words, what things would you like to see change or be different?

1. _____
2. _____
3. _____

What percentage (0-100%) of confidence do you have that you can help yourself reach the three goals you identified above **without any assistance** from therapy?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Not Confident										Total Confidence

What percentage (0-100%) of confidence do you have that you can help yourself reach the three goals you identified above **with assistance** from therapy?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Not Confident										Total Confidence

How **motivated are you to learn new ways** to deal with your problems?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Not Motivated										Completely Motivated

Thank you for the effort and time you have taken to complete this questionnaire. We hope this effort will also help you in better defining and focusing in on the changes you want to make. Please tell us in the space below anything else you would like us to know about you or your background that would help us work with you toward improving your health.

_____

_____

_____

_____