The Neurofeedback Clinic of Northern Colorado

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
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ADOLESCENT INFORMATION FORM

Name_____ Date of 1st Appointment_____ Therapist _____

Date of Birth _____ Age _____ Gender: Male_____ Female_____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address:_____Physician's Phone:_____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer:_____

Current medications being taken:

1)_____ Dosage/Freq _____ Start Date_____ Purpose_____

2)_____ Dosage/Freq _____ Start Date_____ Purpose_____

3)_____ Dosage/Freq _____ Start Date_____ Purpose_____

4)_____ Dosage/Freq _____ Start Date_____ Purpose_____

Prescribed by:_____

Date of last medical evaluation: _____ Date of next appointment:_____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle One) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have allergies? (Circle One) YES NO
Do you have asthma? (Circle One) YES NO

Describe any important medical history, chronic ailments, or other health problems you experience:_____

_____

_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:_____

_____

_____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:_____

_____

_____

SCHOOL AND FAMILY HISTORY

Do you experience any academic problems while in school? (Circle One) YES NO

If yes, please explain:_____

What was the last year of school you completed? _____What school are you currently attending? _____

Who is in your current support network? (friends, relatives, other adults):_____

_____

Please check all information which applies to your biological parents:

MOTHER		FATHER	
	____ living		____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____# of times		____ remarried ____# of times

With whom do you live? Mother____ Father____ Stepmother____ Stepfather____ Guardian ____ Grandparent____

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

_____

List first names and ages of your brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others living in the home with you:

Name	Age	Relationship	Grade/Occupation
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Describe your relationship with your mother:

Currently:_____

_____

In the past:_____

_____

Describe your relationship with your father:

Currently:_____

_____

In the past:_____

Describe your relationship with your stepmother:_____

_____

Describe your relationship with your stepfather:_____

_____

Describe any problems that have occurred in your family relating to:

Alcohol/drug abuse:_____

Sexual/physical/emotional abuse:_____

MENTAL STATUS

Please check any of the following that describe how you believe you feel:

____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ___resentful
____worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ____helpless ___annoyed

Describe any other feelings you have had: _____

_____

Please check any of the following risk-taking behaviors you have engaged in:

___street racing ___gang involvement ___skip school ___dropped out ___dangerous dieting ___cutting ___stealing

___unprotected sex ___running away ___bullying others ___fire starting ___hurt animals ___restrict or restricted food intake ___over exercise

Please check any of the following alcohol/drugs that you currently or have previously used:

____beer ____wine ____hard liquor ____pot ____cocaine ____heroin ____Ecstasy ____speed ___over the counter drugs

____prescription drugs ____ice ____Triple C's ____dones ____quad bars Other: _____

Have you had any change in sleeping habits? (Circle One) YES NO

Describe:_____

_____

Have you had any change in eating habits? (Circle One) YES NO

Describe:_____

_____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates:_____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:_____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:_____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain:_____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO If yes, please

explain:_____

LEVEL OF FUNCTIONING

List any current problems you are having in daily psychological, social or school functioning (i.e. isolation from friends/family, significant difficulty getting to school or completing daily tasks, parent's recent divorce or problems with peers, getting along with family members):

_____

_____

What activities or hobbies do you participate in? _____

_____

Do you participate in regular exercise? (Circle One) YES NO

Describe:_____

How much time do you spend online or gaming?_____

Please circle any of the following concerns that your child or your family may be experiencing:

Nervousness	Toileting	Suicidal Thoughts	Nightmares
Shyness	Depression	Finances	Behavioral Problems
Separation/Divorce	Sexual Problems	Unhappiness	Temper
Drug Use	Alcohol	Work	Death of a Loved One
Anger	Self-Control	Tiredness	Appetite/Eating
Sleep	Stress	Ambition	Parenting
Relaxation	Headaches	Decision Making	Stomach Trouble
Legal Matters	Memory	Concentration	Marital Problems
Energy	Insomnia	Health Problems	Loneliness
Feeling Inferior	Education/School		
Other:_____			

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses:

_____

_____

_____

_____

_____

Please list your Therapy goals:

_____

_____

_____

_____

_____

THANK YOU!