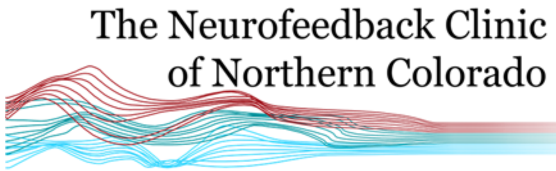

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

ADULT 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? (Check One) YES NO
Please sign here for either answer: ____

Date of last medical evaluation: ________________________ Date of next appointment: ___________________________________

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: ____

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

Hospital	Mo/Yr	Reason
_______________________________________	___________	____
_______________________________________	___________	____
______________________________________	___________	____

Do you have allergies? (Check one) YES NO

Do you have asthma? (Check one) YES NO

Do you use recreational drugs? (Check One) YES NO If no, have you used previously? (Check One) YES NO

If yes, when did you stop? ___________________________________

Type of Drug	How much	How often
____	________________	____
____	________________	____
____	________________	____

Do you drink alcohol? (Check One) YES NO If no, did you drink previously? (Check One) YES NO

If yes, please list:

Type of Alcohol	How much	How often
____	________________	____
____	________________	____

Do you smoke cigarettes? (Check One) YES NO

Do you use other forms of tobacco? (Check One) YES NO If yes, what kind? ____

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

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? YES NO

If yes, please explain:____

____

What was the last year of school you completed? _____________ If you did not complete high school, please explain:

____

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s)_______________________________________ Year(s)_______________________________________

(2) School(s)_______________________________________ Year(s)_______________________________________

(3) School(s)_______________________________________ Year(s)_______________________________________

How would you describe your current support network? (friends, relatives, etc.): _______________________________________

____

Please check all information which applies to your biological parents:

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

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

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

____

Where do your parents live? Mother _______________________________________

Father _______________________________________

Describe your relationship with your mother while growing up: _______________________________________

____

Currently: ____

____

Describe your relationship with your father while growing up: _______________________________________

____

Currently:

____

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
____	_______	____
____	_______	____
____	_______	____
____	_______	____

Describe any family problems which occurred while growing up relating to: Alcohol/drug abuse:

____

____

____

Sexual/physical/emotional abuse: ____

____

____

MARITAL HISTORY

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? _____________________ If living w/someone, how long? _________________________________

Please list your children:

Name	Age	Relationship (biological/step/adopted)	Lives with
________________________________	______	_____________________________	____
________________________________	______	_____________________________	____
________________________________	______	_____________________________	____
________________________________	______	_____________________________	____

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

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

Describe any other feelings you have had: ____

____

What activities or hobbies do you participate in? ____

____

Do you participate in regular exercise? (Check One) YES NO Describe:____

Describe your current working environment: ____

____

Have you had any change in sleeping habits? (Check One) YES NO Describe:____

____

Have you had any change in eating habits?(Check One) YES NO Describe: ____

____

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

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

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

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

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

If yes, please explain:____

Have you ever **considered homicide** in the **past**? (Check One) YES NO

If yes, please explain:

____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, problems with supervisor, etc.):

____

____

____

THOUGHTS: Please check any of the following that apply to you:

_____I sometimes hear voices even though no one nearby is talking to me.

_____I sometimes feel that forces outside of me control me.

_____I sometimes feel that other people control my thoughts.

_____I sometimes have the same thought over and over and cannot control it.

_____I sometimes feel that someone is out to hurt me or do something against me.

_____I am sometimes unable to control my behavior. Please explain:

____

____

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

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

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!