Frontier Health and Wellness

Full Legal Name: _____ Marital Status: _____

Date of Birth: _____ Age: _____ Race/Ethnicity: _____

Gender at Birth: _____ Primary Language: _____

Identified Gender: _____ Sexual Orientation: _____

Occupation: _____ Dominant Hand: _____

Please provide a summary of your understanding of the reason for your referral, as well as the symptoms/concerns that led to the initiation of Neuropsychological Testing**:** _____

_____

_____

PRIMARY REASON FOR REFERRAL

Primary Symptoms	**Severity of Symptom**
	☐Mild ☐Moderate ☐Severe ☐Very Severe ☐Exceedingly Severe ☐Completely Debilitating
	☐Mild ☐Moderate ☐Severe ☐Very Severe ☐Exceedingly Severe ☐Completely Debilitating
	☐Mild ☐Moderate ☐Severe ☐Very Severe ☐Exceedingly Severe ☐Completely Debilitating
	☐Mild ☐Moderate ☐Severe ☐Very Severe ☐Exceedingly Severe ☐Completely Debilitating
	☐Mild ☐Moderate ☐Severe ☐Very Severe ☐Exceedingly Severe ☐Completely Debilitating

PERSONAL HISTORY

Previous significant relationships starting at 18 years of age:

Name of Partner (first name only)	Gender of Partner	Estimated Dates of Relationship	Category of Relationship

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Do you have any children? ☐Yes ☐No If yes, please complete the following:

Name of Child (first name only)	Relationship (Biological/adoptive/step)	Age of Child	Gender	Do they currently live with you?

Current Household

Please list everyone who lives in your current household (aside from children identified above):

Name (first name only)	Relationship	Age	Gender

Please list the moves/relocations you have made since the age of 18 (If Any):

Moved From (City, State)	Moved To (City, State)	Age

Religious Preference

Are you active in a religious practice? ☐Yes ☐No If yes, which religion: _____

How active are you with your religion? ☐Daily ☐Weekly ☐Monthly ☐3-4 times/year

☐ 1-2 times a year ☐ Yearly ☐ N/A

Have you actively participated in other religions? ☐Yes ☐No If yes, which religion(s) and when:

_____

_____

Hobbies/Recreation

Please list any leisure activities/hobbies you enjoy: _____

_____

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Please list any sporting/recreational activities you participate in: _____

_____

Please list any additional areas of interest talent or topics that you are very knowledgeable about: _____

_____

Legal

Have you ever been arrested or been reprimanded by a legal entity? ☐Yes ☐No If yes, list complete the following chart:

Type of incident (theft, DUI, Possession, etc.)	Your age when the incident occurred	Charges filed	Convictions (please state if case is still open)	Jail/Prison Time? Dates?	Fines? Amount?

Additional Details: _____

_____

_____

OCCUPATIONAL HISTORY

Current Occupation: _____ Length of time in this specific field? _____

Employer: _____ Length of current employment: _____

Secondary Occupation/Employer (if applicable): _____

_____

Please list previous places of employment:

Occupation	Employer	Title	Employment dates	Reason for leaving

Working difficulties (related to productivity): _____

_____

Working difficulties (related to co-workers): _____

_____

Working difficulties (related to superiors): _____

_____

FAMILY SOCIAL HISTORY

Please complete the following regarding your parents or primary caregiver(s)

Parents/Caregiver	Name (First Name Only)	Gender	Highest Level of Education	Primary Occupation	Age	Deceased
Mother						☐Yes ☐No
Father						☐Yes ☐No
Step/Adoptive Mother						☐Yes ☐No
Step/Adoptive Father						☐Yes ☐No
Caregiver						☐Yes ☐No
Caregiver						☐Yes ☐No

Please complete the following regarding your sibling(s)

Name (First Name Only)	Gender	Highest Level of Education	Primary Occupation	Age	Deceased
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No

BIRTH HISTORY

Please select the way in which you were delivered.

☐Vaginal Birth
☐ Induced Labor
☐ Beech Birth
☐ Forceps Used
☐ Planned Cesarean
☐ Emergency Cesarean
☐ Unknown

Where were you born? _____ Birth Weight: _____ Birth Length: _____

Were you born premature? ☐Yes ☐No (If Yes) How many weeks early?_____

Are you aware of any medical problems/conditions your mother experienced while pregnant with you (i.e., gestational diabetes, hospitalizations, surgeries, etc.)? _____

_____

_____

_____

Are you aware of any substance use by your mother while pregnant with you? (Please include substances such as NSAIDs, nicotine and marijuana.) Yes ☐ No ☐ (If Yes)

What substance(s):_____
How Much? _____

Are you aware of any complications that occurred to you during/at the time of your birth?

☐ Labor did not progress
☐ Abnormal Heartrate
☐ Umbilical Cord Issues
☐ Blood Transfusion(s)
☐ Needed Oxygen
☐ Jaundice
☐ Extended Hospital Stay
☐ Brain Bleed
☐ Difficulty Breathing

Other: _____

_____

Were you admitted to the NICU? ☐Yes ☐ No (If Yes) For How Long? _____

Were you adopted? ☐Yes ☐ No (If Yes) Age of Adoption: _____

Were you ever in Foster Care? ☐Yes ☐ No (If Yes) Estimated Dates: _____

INFANCY/TODDLER

Did you experience any delays in meeting your developmental milestones? ☐Yes ☐No

(If yes) what was the delay? ☐ Speech/Language ☐ Toilet Training ☐Motor skills ☐ Walking

Other: _____

Medical Concerns
Prior to 4 years of age did you experience any of the following:

☐ Delayed Growth
☐ Seizures
☐ Malnourishment
☐ Severe Allergies
☐ Surgical Interventions
☐ Ear pain or infections
☐ Impaired Hearing
☐ Impaired Vision
☐ Childhood Meningitis
☐ Anemia
☐ Ear Tubes

Other Medical Conditions: _____

Any other concerns or experiences that occurred prior to 4 years of age that you feel have affected your life negatively in any way?

_____

_____

_____

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Behavioral Concerns

Prior to 4 years of age did you experience any of the following:

- ☐ Easy to angry
- ☐ Frequent tantrums
- ☐ Property destruction
- ☐ Violence towards others
- ☐ Trouble with attention
- ☐ Hyperactivity
- ☐ Picky Eating Habits
- ☐ Frequently forgetful
- ☐ Anxiety
- ☐ Social Isolation
- ☐ Separation Anxiety
- ☐ Frequent nightmares
- ☐ Difficulty Sleeping
- ☐ Difficulty with change
- ☐ Difficulty with authority
- ☐ Sensitivity to Sound
- ☐ Sensitivity to Touch

GRADE SCHOOL

List the schools attended from kindergarten to 12th Grade (or GED Equivalent)

School Name	Public or Private	City	State	Grades Attended

High School GPA (approximate): _____ Did you graduate? ☐Yes ☐No GED? ☐Yes ☐No

Extracurricular activities you participated in (Sports, Music, Arts, Clubs etc.): _____

_____

_____

Educational Modifications/Supports

Please check the following that applied to your experience in grade school.

- ☐ IEP.
  If yes, what grades(?) _____
- ☐ 504
  If yes, what grades(?) _____
- ☐ Held back.
  If yes, what grades(?) _____
- ☐ Skip grade(s).
  If yes, what grades(?) _____
- ☐ Disorganization
- ☐ Talking Too Much
- ☐ Interrupting Others
- ☐ Frequently Late
- ☐ Missing Assignments
- ☐ Special Education Classes
- ☐ Diagnosed Learning Disability
- ☐ Speech Therapy
- ☐ Poor/Failing Grades
- ☐ Repeated Classes/Summer School
- ☐ Tutoring
- ☐ Lack of Motivation
- ☐ Problems Concentrating
- ☐ Gifted Program
- ☐ Poor Time Management

Other modifications or supports you received during grade school? _____

_____

Other factors that detracted from your ability to be successful in school? _____

_____

What would you consider your strongest academic area(s)? _____

What would you consider your weakest academic area(s)? _____

Social

Please check the following that applied to your experience in grade school.

- ☐ Small (3-5) consistent friend group
- ☐ Large social network
- ☐ 1-2 close friends
- ☐ Friends did not attend same school
- ☐ Little to no social interactions
- ☐ Did not enjoy socializing

Please list the moves/relocations you made prior to the age of 18 (If Any):

Moved From (City, State)	Moved To (City, State)	Age/Grade

POST-SECONDARY EDUCATION/EXPERIENCE

After high school you -

- ☐ Began Working/Started Career
- ☐ Joined the Military (questions below)
- ☐ Attended College/University (questions below)
- ☐ Attended Trade School (questions below)
- ☐ Attended Community College (questions below)
- ☐ Other: _____

Military

Highest Earned Rank: _____ Branch: _____

Sector Worked/Primary Job_____

Age of Enlistment _____ Are you still enlisted ☐Yes ☐No If No, Age of Retirement: _____

Deployments ☐Yes ☐No If yes, please complete the following:

Age deployed	Length of deployment	Job while deployed	Location of deployment

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College/University (Undergraduate and Post-Graduate) – Trade School – Community College

School/Program Attended	Year(s)Attended	Area of Focus/Study (Major/Minor)	GPA (approximate)	Graduated/Completed Certification/Degree (if applicable)

FAMILY MEDICAL HISTORY

Condition	Person(s) who was/is affected by condition	Maternal or Paternal Side
Cancer	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
High Blood Pressure	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Stroke	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Diabetes	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
High Cholesterol	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Blood Disorder/Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Heart Problems/Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Kidney Problems/Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Liver Problems/Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Lung Problems/Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Alzheimer's Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Dementia	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Seizure Disorder	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Sleep Disorder	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Thyroid Disorder	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal

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Multiple Sclerosis	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Parkinson's Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Huntington's Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Other Neurological Disorder(s) - _____	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Other Genetic Disorder(s) - _____	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal

Please list any other significant family medical history that is not listed above and/or please provide any significant details regarding any of the responses above: _____

_____

_____

FAMILY PSYCHIATRIC HISTORY

Condition	Person(s) who was/is affected by condition	Maternal or Paternal Side
ADHD	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Anxiety	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Depression	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Bipolar Disorder	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Obsessive Compulsive Disorder	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Schizophrenia	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
PTSD	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Autism	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Learning Disabilities	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Speech/Language Disorder(s)	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Drug Abuse/Addiction	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal

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Alcoholism	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Other behavioral problems/disorders – _____	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal

Please list any other significant family psychiatric history that is not listed above and/or please provide any significant details regarding any of the responses above: _____

_____

_____

PERSONAL MEDICAL HISTORY

Height: ____ feet _____ inches Weight: _____pounds

Please check all current and previous medical conditions:

Autoimmune:

Psoriasis	☐Current	☐Past	HIV/AIDS	☐Current	☐Past
Rheumatoid Arthritis	☐Current	☐Past	Type 1 Diabetes	☐Current	☐Past
Celiac Disease	☐Current	☐Past	Graves' Disease	☐Current	☐Past

Brain/Neurological:

Alzheimer's Disease	☐Current	☐Past	Multiple Sclerosis	☐Current	☐Past
ALS	☐Current	☐Past	Seizures/Epilepsy	☐Current	☐Past
Dementia	☐Current	☐Past	Head Injury/TBI	☐Current	☐Past
Meningitis	☐Current	☐Past	Concussion	☐Current	☐Past
Stroke	☐Current	☐Past	Migraines	☐Current	☐Past
Brain Tumor	☐Current	☐Past	Bell's Palsy	☐Current	☐Past
Parkinson's Disease	☐Current	☐Past	Vascular Dementia	☐Current	☐Past

Bone/Joint

Arthritis	☐Current	☐Past	Gout	☐Current	☐Past
Bursitis	☐Current	☐Past	Scoliosis	☐Current	☐Past
Fibromyalgia	☐Current	☐Past	Osteoarthritis	☐Current	☐Past

Digestive

Crohn's Disease	☐Current	☐Past	IBS	☐Current	☐Past
GERD	☐Current	☐Past	Ulcerative Colitis	☐Current	☐Past
Hiatal Hernia	☐Current	☐Past	Diverticulitis	☐Current	☐Past
Constipation	☐Current	☐Past	Incontinence	☐Current	☐Past

Heart/Cardiovascular

Cardiomyopathy	☐Current	☐Past	Heart Attack	☐Current	☐Past
Coronary Artery Disease	☐Current	☐Past	High Blood Pressure	☐Current	☐Past

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Arrhythmias	☐Current	☐Past	Heart Disease	☐Current	☐Past
Heart Failure	☐Current	☐Past	Aorta Disease	☐Current	☐Past

Respiratory

Asthma	☐Current	☐Past	Emphysema	☐Current	☐Past
Bronchitis	☐Current	☐Past	Pneumonia	☐Current	☐Past
COPD	☐Current	☐Past	TB	☐Current	☐Past
Cystic Fibrosis	☐Current	☐Past	Allergies	☐Current	☐Past

Other

Prediabetes	☐Current	☐Past	Type 2 Diabetes	☐Current	☐Past
Gestational Diabetes	☐Current	☐Past	Macular Degeneration	☐Current	☐Past
Cancer	☐Current	☐Past	Sleep Apnea	☐Current	☐Past
Glaucoma	☐Current	☐Past	Narcolepsy	☐Current	☐Past
Kidney Disease Specific Condition: _____	☐Current	☐Past	Insomnia	☐Current	☐Past
Liver Disease Specific Condition: _____	☐Current	☐Past	Deafness/hearing loss ☐ Right Ear ☐ Left Ear ☐ Bilateral	☐Current	☐Past
Blood Disease Specific Condition: _____	☐Current	☐Past	Toxic Exposure Exposure to_____ On (Date)_____	☐Current	☐Past
Serious Infection Type of Infection: _____ _____	☐Current	☐Past	Poisoning Exposure to_____ On (Date)_____	☐Current	☐Past
Radiation/Chemotherapy	☐Current	☐Past	Other Condition(s) _____	☐Current	☐Past

Please list any past surgical procedures:

Surgery	Date of Surgery	Hospital/Clinic	Doctor/Surgeon	Complications
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

If you checked yes to complications, please explain here:

_____

_____

Please list any past overnight hospitalizations

Reason for Hospitalization	Dates Inpatient	Hospital/Clinic	Complications
			☐Yes ☐No

			☐Yes ☐No
			☐Yes ☐No

If you checked yes to complications, please explain here:

_____

_____

MEDICATION HISTORY

Please list all medications you are currently taking:

Medication Name	Dosage	Frequency which it is taken	Date when 1st prescribed	Prescribed for

Please list all supplements you are currently taking:

Supplement Name	Dosage	Frequency which it is taken	Date when 1st started taking	Taken for

Please list all psychiatric medications you have taken:

Medication Name	Dosage	Frequency which it is taken	Prescribed for	Reason for stopping

PERSONAL PSYCHIATRIC HISTORY

Please check all current and previous psychiatric conditions:

ADHD	☐Current ☐Past	Insomnia	☐Current ☐Past
Difficulty Paying Attention	☐Current ☐Past	Fatigue	☐Current ☐Past
Anxiety	☐Current ☐Past	Difficulty Staying Asleep	☐Current ☐Past
Feelings of Panic	☐Current ☐Past	Frequent Nightmares	☐Current ☐Past
Panic Attacks	☐Current ☐Past	Loss of Appetite	☐Current ☐Past
Social Anxiety	☐Current ☐Past	Binge Eating	☐Current ☐Past
Depression	☐Current ☐Past	Over-Eating	☐Current ☐Past

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Bipolar Disorder	☐Current ☐Past	Anorexia	☐Current ☐Past
Periods of Mania	☐Current ☐Past	Bulimia	☐Current ☐Past
Periods of Hypomania	☐Current ☐Past	Suicidality	☐Current ☐Past
Schizophrenia	☐Current ☐Past	Self-Deprecating Thoughts	☐Current ☐Past
Emotional Dysregulation	☐Current ☐Past	Self-Harm	☐Current ☐Past
Obsessive Compulsive Disorder	☐Current ☐Past	Homicidal Thoughts	☐Current ☐Past
Debilitating Phobias	☐Current ☐Past	Chronic Headaches	☐Current ☐Past
Reduced or no sex drive	☐Current ☐Past	Intermittent dizziness	☐Current ☐Past
Increased sex drive	☐Current ☐Past	Noise sensitivity	☐Current ☐Past

Please describe any other psychiatric conditions or symptoms you are currently or have previously experienced: _____

_____

_____

Please list all current or previously diagnosed psychiatric conditions:

Diagnosis	Age of diagnosis	Provider who made diagnosis	Current or Previous
			☐Current ☐Previous
			☐Current ☐Previous
			☐Current ☐Previous
			☐Current ☐Previous

Additional Information: _____

_____

_____

TRAUMATIC BRAIN INJURY/STROKE HISTORY (If applicable)

Type of Injury/Accident: _____ Date of Injury/Accident: _____

Description of Accident/Injury: _____

_____

_____

Were there any other associated injuries obtained at the time of the accident/injury? ☐Yes ☐No If yes, please explain : _____

_____

_____

Medical Interventions: ☐ MRI ☐ CT ☐ Surgery ☐ Overnight Supervision ☐ Hospitalization ☐ Other:_____

_____

Was there loss of consciousness? ☐ Yes ☐ No If yes, for how long:_____

Was there loss of oxygen to the brain? ☐ Yes ☐ No If yes, for how long: _____

Changes in physiological functioning:

☐ Numbness (specify below)
☐ Weakness (specify below)
☐ Dizziness
☐ Headaches
☐ Blurred Vision
☐ Vomiting
☐ Poor Balance
☐ Poor Coordination

Long term effects/symptoms from the accident/injury: _____

_____

_____

Changes in personality and/or cognitive functioning:

☐ Memory Problems
☐ Verbal Communication
☐ Problems Learning New Information
☐ Irritability
☐ Poor Anger Control
☐ Attention/Concentration Issues
☐ Depressed Mood
☐ Anxiety
☐ Impulsivity
☐ Frequent Crying
☐ Executive functioning
☐ Decrease in smell
☐ Decrease in taste
☐ Decreased processing speed

Additional Information: _____

_____

_____

SUBSTANCE ABUSE HISTORY (If applicable)

Please list any/all substances you have used/consumed:

Substance	Frequency of use (Daily/weekly/socially, etc.)	Average amount used/consumed	Age 1st exposed	Date of last use	Date stopped/ quit
Caffeine					
Tobacco/Nicotine					
Alcohol					
Marijuana					
Opioid/Prescription Drugs					
Inhalants					
Hallucinogens (Mushrooms, LSD)					
Stimulants (Cocaine, Meth, Crack etc.)					
Other: _____					

Have you experienced any legal problems due to consumption/use of substances? ☐Yes ☐No If yes, which substance(s)? _____

Please Explain: _____

_____

Have you experienced any personal/relationship problems due to consumption/use of substances? ☐Yes ☐No If yes, which substance(s)? _____

Please Explain: _____

_____

TRAUMA HISTORY (If applicable)

Please complete the information below based on experiences form your childhood AND adulthood.

Have you ever been:

Physically Abused and/or Assaulted ☐ Yes ☐ No If yes, please answer the following:

Dates/Time frame of assault: _____ Perpetrator(s): _____

Medical Intervention/Therapy Services: _____

Legal Ramifications/Intervention: _____

Sexually Abused and/or Assaulted ☐ Yes ☐ No If yes, please answer the following

Dates/Time frame of assault: _____ Perpetrator(s): _____

Medical Intervention/Therapy Services: _____

Legal Ramifications/Intervention: _____

Experienced Emotional and/or Physical Neglect ☐ Yes ☐ No If yes, please answer the following

Dates/Time frame of neglect: _____ Perpetrator(s): _____

Additional Information: _____

_____

Other Significant Traumatic Events/Experiences (i.e., witnessing violence, life threatening situation, fear for safety etc.)

☐Yes ☐ No If yes, please answer the following

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Dates/Time frame of event: _____ Perpetrator(s): _____

Brief description of the traumatic event/experience: _____

_____

_____

Current symptoms that you are experiencing as a result of the above listed trauma

- ☐ Intrusive Thoughts
- ☐ Nightmares
- ☐ Memory Loss
- ☐ Self-Deprecating Thoughts
- ☐ Self-Isolation
- ☐ Easily Angered
- ☐ Hypervigilance
- ☐ Poor Concentration
- ☐ Insomnia
- ☐ Flashbacks
- ☐ Heightened Startle Response
- ☐ High Risk Behavior

Other:_____

_____

ADDITIONAL INFORMATION:

_____

_____

_____

_____

_____

_____