Bayside Neurotherapy

Intake Information
(to be completed by client and/or legal guardian)

Please complete the following questionnaire. This information will be discussed more thoroughly in session and used to determine goals for treatment.

Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Telephone Number: _____ _____
Home Work

Can I leave a message at home? ☐Yes ☐No Can I leave a message at work? ☐Yes ☐No

Can you be reached by Email? ☐Yes ☐No Email address: _____

Occupation: _____ Employer: _____

Highest level of education: _____

How satisfied are you with your job? _____

Briefly describe your reason(s) for seeking help at this time: _____

_____

What do you wish to accomplish through the process of therapy? _____

_____

Marital/Relationship Status (check all that apply):

☐Married ☐Separated ☐Widowed ☐Divorced ☐Remarried

☐Single ☐Long term relationship ☐Cohabitating

Other: _____

Current partner's name: _____ Occupation: _____

Length of relationship: _____ How satisfied are you with this relationship?_____

Do you have any children (biological, adopted, foster, step, etc.)? ☐Yes ☐No

If yes, please list names and ages:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Do your children currently live with you? ☐Yes ☐No

If no, where do they live? _____

Have you ever been in therapy before? ☐Yes ☐No

If yes, briefly describe the reason(s), date(s), and length of treatment: _____

_____

Was it a positive experience? ☐Yes ☐No

Your basic health? ☐Good ☐Fair ☐Poor

When was your last physical exam? _____

Who is your Physician? _____

Do you have any difficulty sleeping? ☐Yes ☐No

If yes, please describe briefly: _____

Do you have any chronic illnesses, medical conditions, or injuries? ☐Yes ☐No

If yes, please describe: _____

Have you ever had any head injuries or concussions? ☐Yes ☐No

Are you presently taking any medication, herbs, supplements, etc.? ☐Yes ☐No

If yes, please list: _____

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of?

☐Yes ☐No If yes, what?: _____

Have you ever been hospitalized? ☐Yes ☐No

If so, for what? _____

What do you enjoy doing in your spare time? _____

Are there things that you used to do, or would like to do, but currently don't? _____

How would you describe your spiritual or religious beliefs?_____

Please describe anything else you think would be important for me to know about you, your family or family history?

_____

_____

Did someone refer you? ☐Yes ☐No If yes, who? _____

May I contact him or her? ☐Yes ☐No

Please circle any of the following that presently cause you difficulty:

Assertiveness	Parenting	Digestive issues	Nightmares
Bedwetting	Nervousness	Physical abuse	Education
Temper	Stress	Memory	Headaches
Unhappiness	Grief	In-laws	Health problems
Alcohol use	Sexual problems	Loneliness	Ulcers
Energy	Children	Divorce / Separation	Depression
Inferiority	Drug use	Finances	Fears
Past Trauma	My past	Career choices	Legal matters
Marriage	Concentration	My thoughts	Sleep
Parents	Relaxation	Sexual abuse	Friends
Sadness	Appetite	Work	Self-control
Guilt	Confusion	Self-concept	Religion
School	Suicidal thoughts	Decision making	Insomnia
Ambition	Shyness	Dating	Fatigue

Other: _____

Now put an * by the items that are causing you the MOST difficulty.