NeuroDevelopment, LLC
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Fort Collins, CO 80525
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Today's Date_____ Referred By:_____

Patient Name_____ DOB_____ Age_____

Address_____ Phone # _____

City_____ State_____ Zip Code _____ Cell Phone #_____

Email Address_____ Insurance Provider_____

Employer_____ Phone #_____

Single ☐ Married ☐ Divorced/Separated ☐ Widow/er ☐

Spouse's Name_____ Phone #_____

Children_____ Names and Ages_____

_____

High School_____ If Graduate-Year_____

College_____ Major_____ If Graduate-Year_____

Primary Care Physician_____ Phone #_____

MEDICAL / DEVELOPMENTAL HISTORY

Meningitis	Yes ☐ No ☐ Age____	Asthma	Yes ☐ No ☐ Age____
Encephalitis	Yes ☐ No ☐ Age____	Convulsions	Yes ☐ No ☐ Age____
High Fever	Yes ☐ No ☐ Age____	Head Injuries	Yes ☐ No ☐ Age____
Abscessed Ears	Yes ☐ No ☐ Age____	Hospitalizations	Yes ☐ No ☐ Age____
Allergies	Yes ☐ No ☐ Age____	Operations	Yes ☐ No ☐ Age____
Extended Illness	Yes ☐ No ☐ Age____	Epilepsy/Seizures	Yes ☐ No ☐ Age____
Diabetes	Yes ☐ No ☐ Age____	Stroke	Yes ☐ No ☐ Age____

If you answered "Yes" to any of the above, please describe below:_____

_____

_____

_____

Current medical concerns: _____

_____

_____

Current medications:_____

_____

Previous counseling/therapy Yes ☐ No ☐ When_____ Where_____

Name of therapist(s)_____

Did you experience learning problems at school Yes ☐ No ☐ If yes, please describe: _____

_____

PRESENT HEALTH/SOCIAL ISSUES

Are you having any concerns with sleeping habits Yes ☐ No ☐ Check below if applicable:

Too little ☐ Too much ☐ Poor Quality ☐ Disturbing dreams ☐ Other ☐ _____

How many times per week do you exercise _____ Duration_____

Do you have concerns regarding appetite/eating habits Yes ☐ No ☐ Check below if applicable:

Eating less ☐ Eating more ☐ Significant weight loss/gain ☐

Do you use alcohol regularly Yes ☐ No ☐ Frequency_____/week

Do you engage in recreational drug use? Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐

Including family, approximately how many people can you count on for emotional support? _____

FAMILY BACKGROUND

Past/Present concerns: (Check applicable) Death ☐ Divorce ☐ Frequent relocations ☐

Debilitating injury/disability ☐ Substance abuse ☐ Serious illness ☐ Psychiatric disorder ☐

Physical/sexual abuse ☐ Financial crisis/unemployment ☐ Legal problems ☐ Eating disorders ☐

Attempted/completed suicide ☐ Other ☐

If you checked any of the above, please describe below:_____

_____

_____

_____

CURRENT CONCERNS

Briefly describe the concerns you would most like help with:

_____

_____

_____

_____

_____

_____