Minnesota Neurotherapy Institute – HISTORY – 4 Pages!

Client Initials Only: _____ **Age:** _____ **DOB:** _____

Referral source if referred to this office: _____
_____ **Phone:** _____

Diagnosis and/or presenting complaints:
_____
_____
_____

Current medications:
_____
_____

Briefly list other approaches you have tried for this condition: (Medication, behavior therapy, counseling, alternative medicine, etc.?)
_____
_____
_____
_____

Developmental History – Please indicate your (or your child's) history in relation to the following:

Prenatal and Birth	**Yes**	**No**	**Details – Please provide additional details on Page 3**
Prenatal stress or injury	___	___	_____
Prenatal drug/alcohol exposure	___	___	_____
Birth trauma (forceps, breech, etc.)	___	___	_____
Anesthesia, pain medications	___	___	_____
Anoxia (oxygen deprivation @ birth)	___	___	_____
Premature/late delivery	___	___	_____
Medical problems after birth	___	___	_____

Birth weight _____ Adopted at age _____ Other _____

Growth and Development	**Typical**	**More**	**Less**	**Details – Please use page 3 if needed**
Activity level	_____	____	_____	_____
Motor/coordination development	_____	____	_____	_____
Infections/allergies	_____	____	_____	_____
Emotional development	_____	____	_____	_____
Behavior concerns	_____	____	_____	_____
Appetite/digestion	_____	____	_____	_____
Language/speech development	_____	____	_____	_____

Right Handed? Left Handed? ← **Please Answer This Question – Circle One**

Physical Traumas: Please *Respond to these questions!*

	Yes	No	Details– Please provide additional details on Page 3
Head injury (even minor falls, etc.)	___	___	_____
Coma (loss of consciousness)	___	___	_____
Accidents (list all)	___	___	_____
High fever	___	___	_____
Serious illness	___	___	_____
Surgery	___	___	_____
CNS infection	___	___	_____
Drug overdose/poisoning	___	___	_____
Recreational drug use	___	___	_____
Anoxia (O2 deprivation since birth)	___	___	_____
Stroke	___	___	_____
Psychological Stress/Life Changes	**Yes**	**No**	**Details– Please provide additional details on Page 3**
Death in family	___	___	_____
Divorce/remarriage	___	___	_____
Move/relocation	___	___	_____
School change	___	___	_____
Job change	___	___	_____
Family member chronic illness	___	___	_____

Symptom Checklist Indicate if the **client** and/or **family member(s)** (parents, grandparents, brothers, sisters, etc.) **currently experience** or have a **history** of any of the following symptoms. ***Be sure to check √ if Current***.

Symptom	√ if client	√ if family	√ if current
Feeling Tense	_____	_____	_____
Depressed	_____	_____	_____
Always on the go	_____	_____	_____
School/work problem	_____	_____	_____
Impulsivity	_____	_____	_____
Hyperactivity	_____	_____	_____
Attention problems	_____	_____	_____
Behavior problems	_____	_____	_____
Vocal or motor tics	_____	_____	_____
Sleep problems	_____	_____	_____
Legal trouble	_____	_____	_____
Headaches	_____	_____	_____
Feeling lonely	_____	_____	_____
Frequent illness	_____	_____	_____
Repetitive thoughts	_____	_____	_____
Repetitive behavior	_____	_____	_____

Symptom	√ if client	√ if family	√ if current
Stubbornness	_____	_____	_____
Addictions	_____	_____	_____
Bowel disturbances	_____	_____	_____
Chronic fatigue/FMS	_____	_____	_____
Inferiority feelings	_____	_____	_____
Dizziness	_____	_____	_____
Fainting spells	_____	_____	_____
Heart palpitations	_____	_____	_____
Stomach trouble	_____	_____	_____
Poor appetite	_____	_____	_____
Picky eater	_____	_____	_____
Nightmares	_____	_____	_____
Alcohol/drug problem	_____	_____	_____
Feeling panicky	_____	_____	_____
Tremors	_____	_____	_____
Suicidal ideas	_____	_____	_____

Symptom	√ if client	√ if family	√ if current
Shy with People	_____	_____	_____
Allergies	_____	_____	_____
Asthma	_____	_____	_____
Seizures	_____	_____	_____
Chronic pain	_____	_____	_____
Food sensitivity	_____	_____	_____
Head injury	_____	_____	_____
Memory problems	_____	_____	_____
Temper tantrums	_____	_____	_____
Rages	_____	_____	_____
Verbal Aggression	_____	_____	_____

Symptom	√ if client	√ if family	√ if current
PMS	_____	_____	_____
Physical/sexual abuse	_____	_____	_____
Over ambitious	_____	_____	_____
Unable to relax	_____	_____	_____
Can't make decisions	_____	_____	_____
Communication prob.	_____	_____	_____
Problems at home	_____	_____	_____
Financial problems	_____	_____	_____
Physical Aggression	_____	_____	_____

Other, specify: _____

In above list, please circle the most important issues or those that cause the greatest difficulties.

Please provide additional details for any items indicated in previous pages: _____

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Continue to Page 4 Head Injury Questionnaire

Head Injury Questionnaire

This questionnaire is designed to determine whether you have ever had a significant head injury. Please read the questions and think carefully about your history. It is common for people to forget head injuries, car accidents, minor falls, etc. unless followed by a loss of consciousness or significant impairment. ***We are interested in ALL injuries.***

Event	Yes	No	List events and dates	Low ← Severity → High
Have you ever had an injury involving an impact to your head?			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s ____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____ _____
Were you ever in a motor vehicle, skate board, skiing, bike or other accident?			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s ____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____ _____
Were you told that you fell as a child (down stairs, off a table or chair, at a park?)			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s ____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____ _____
Ever been in a fight, been beaten or attacked, passed out from alcohol?			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s ____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____ _____