



Neuroeducation, Inc., P.C.
Psychological & Educational Evaluations & Treatment

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Were you were referred to us by: Doctor () _____ (name)
Teacher (), Friend (), Relative (), Other () _____

If not referred, how did you find us? Internet search (), Advertisement (),
Phone Book (), Other () _____

Today's Date _____

Name _____ Birthdate _____ Age _____

Home Address _____ City _____ State/Zip _____

Social Security Number _____ Work Phone _____

Home/Cell Phone _____ Email _____

Employed by _____ Occupation _____

Insurance _____ Policy Number _____

Living with Spouse/Significant Other? _____ Name _____

Children? _____ Names/Ages _____

High School _____ If Graduate, Year _____

College _____ Major _____ If Graduate, Year _____

Family Physician _____ Phone _____ Fax _____

Are you taking any medication(s) now? Yes () No ()

MEDICAL HISTORY

Have you had:

	Yes	No	Age		Yes	No	Age
Meningitis	___	___	___	Asthma	___	___	___
Encephalitis	___	___	___	Seizures	___	___	___
High Fever	___	___	___	Head Injury	___	___	___
Ear Infections	___	___	___	Hospitalized	___	___	___
Allergy	___	___	___	Operations	___	___	___
Extended Illness	___	___	___	Broken Bones	___	___	___

Describe those above _____

Describe any current medical conditions

Have you had previous counseling or therapy of any kind?
When _____
Why _____
Name of Therapist _____