

NYOO MIND BIBLICAL COUNSELING COUNSELEE INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer or would prefer to discuss with your counselor. Information you provide here is held to the same standards of confidentiality as our counseling.

PERSONAL INFORMATION

Name: _____

Age: _____

Address: _____

Telephone: _____ (cell) (work) (home)

Email: _____

TREATMENT HISTORY

Are you currently receiving services, professional counseling or psychotherapy elsewhere? () yes () no

Have you had previous counseling?

() no

() yes, with (previous counselor's name) _____

Are you currently taking prescribed medication (antidepressants or others)?

() yes () no

If yes, please list: _____

Prescribed by: _____

Would you be interested in exploring other alternative treatments that may assist or replace the medications you currently have? () yes () no

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? yes no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? yes no

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

Are you currently on medication to manage a physical health concern? If yes, please list:

Are you having any problems with your sleep habits? yes no

If yes, check where applicable:

Sleeping too little Sleeping too much Poor quality sleep
 Disturbing dreams other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? no yes

If yes, check where applicable: Eating less Eating more Bingeing
 Restricting

Have you experienced significant weight change in the last 2 months? no yes

Do you regularly use alcohol? no yes

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

How often do you engage recreational drug use? () daily () weekly () monthly () rarely () never

Do you smoke cigarettes or use other tobacco products? () yes () no

Have you had suicidal thoughts recently?
() frequently () sometimes () rarely () never

Have you had them in the past?
() frequently () sometimes () rarely () never

Are you currently in a romantic relationship (married or otherwise)? () no () yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: _____

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing)	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

OCCUPATIONAL INFORMATION

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/ authorized representative to who it pertains unless other permitted by law.

Are you currently employed? () no () yes

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any _____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? () no () yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? () no () yes

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	Yes / No	Family member
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

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OTHER INFORMATION

What do you consider to be your strengths? _____

What do you like most about yourself? _____

What are effective coping strategies that you have learned? _____

What are your goals for counseling?

If someone asked the question “What is truth?” What would you tell them?

If someone asked the question “Who are you?” What would you tell them?

If someone asked the question “Why are you here?” What would you tell them?

If someone asked the question “What is the point of suffering?” What would you tell them?

If someone asked the question “What is your purpose in life?” What would you tell them?

If someone asked the question “What is eternal life?” What would you tell them?



Brain Region Localization Form

INSTRUCTIONS:

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KEY:

0 = I never have symptoms (0% of the time)
 1 = I rarely have symptoms (Less than 25% of the time)
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Frontal lobe Prefrontal, Dorsolateral and Orbitofrontal (Areas 9, 10, 11, and 12)		Level	Frontal Lobe Precentral and Supplementary Motor Areas (Area 4 and 6)		Level
1.	Difficulty with restraint and controlling impulses or desires	0 1 2 3 4	18.	Initiating movements with your arm or leg has become more difficult	0 1 2 3 4
2.	Emotional instability (lability)	0 1 2 3 4	19.	Feeling of arm or leg heaviness, especially when tired	0 1 2 3 4
3.	Difficulty planning and organizing	0 1 2 3 4	20.	Increased muscle tightness in your arm or leg	0 1 2 3 4
4.	Difficulty making decisions	0 1 2 3 4	21.	Reduced muscle endurance in your arm or leg	0 1 2 3 4
5.	Lack of motivation, enthusiasm, interest and drive (apathetic)	0 1 2 3 4	22.	Noticeable difference in your muscle function or strength from one side to the other	0 1 2 3 4
6.	Difficulty getting a sound or melody out of your thoughts (Perseveration)	0 1 2 3 4	23.	Noticeable difference in your muscle tightness from one side to the other	0 1 2 3 4
7.	Constantly repeat events or thoughts with difficulty letting go	0 1 2 3 4	Frontal Lobe Broca's Motor Speech Area (Area 44 and 45)		Level
8.	Difficulty initiating and finishing tasks	0 1 2 3 4	24.	Difficulty producing words verbally, especially when fatigued	0 1 2 3 4
9.	Episodes of depression	0 1 2 3 4	25.	Find the actual act of speaking difficult at times	0 1 2 3 4
10.	Mental fatigue	0 1 2 3 4	26.	Notice word pronunciation and speaking fluency change at times	0 1 2 3 4
11.	Decrease in attention span	0 1 2 3 4	Parietal Somatosensory Area and Parietal Superior Lobule (Areas 3, 1, 2 and 7)		Level
12.	Difficulty staying focused and concentrating for extended periods of time	0 1 2 3 4	27.	Difficulty in perception of position of limbs	0 1 2 3 4
13.	Difficulty with creativity, imagination, and intuition	0 1 2 3 4	28.	Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall	0 1 2 3 4
14.	Difficulty in appreciating art and music	0 1 2 3 4	29.	Frequently bumping body or limbs into the wall or objects accidentally	0 1 2 3 4
15.	Difficulty with analytical thought	0 1 2 3 4	30.	Reoccurring injury in the same body part or side of the body	0 1 2 3 4
16.	Difficulty with math, number skills and time consciousness	0 1 2 3 4			
17.	Difficulty taking ideas, actions, and words and putting them in a linear sequence	0 1 2 3 4			



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Parietal Inferior Lobule (Area 39 and 40)		Level	Medial Temporal lobe and Hippocampus		Level
32.	Right/left confusion <input type="checkbox"/> L	0 1 2 3 4	49.	Memory less efficient	0 1 2 3 4
33.	Difficulty with math calculations <input type="checkbox"/> L	0 1 2 3 4	50.	Memory loss that impacts daily activities	0 1 2 3 4
34.	Difficulty finding words <input type="checkbox"/> L	0 1 2 3 4	51.	Confusion about dates, the passage of time, or place	0 1 2 3 4
35.	Difficulty with writing <input type="checkbox"/> L	0 1 2 3 4	52.	Difficulty remembering events	0 1 2 3 4
36.	Difficulty recognizing symbols or shapes <input type="checkbox"/> R	0 1 2 3 4	53.	Misplacement of things and difficulty retracing steps	0 1 2 3 4
37.	Difficulty with simple drawings <input type="checkbox"/> R	0 1 2 3 4	54.	Difficulty with memory of locations (addresses) <input type="checkbox"/> R	0 1 2 3 4
38.	Difficulty interpreting maps <input type="checkbox"/> R	0 1 2 3 4	55.	Difficulty with visual memory <input type="checkbox"/> R	0 1 2 3 4
Temporal Lobe Auditory Cortex (Areas 41, 42)		Level	56.	Always forgetting where you put items such as keys, wallet, phone, etc. <input type="checkbox"/> R	0 1 2 3 4
39.	Reduced function in overall hearing	0 1 2 3 4	57.	Difficulty remembering faces <input type="checkbox"/> R	0 1 2 3 4
40.	Difficulty interpreting speech with background or scatter noise	0 1 2 3 4	58.	Difficulty remembering names with faces <input type="checkbox"/> L	0 1 2 3 4
41.	Difficulty comprehending language without perfect pronunciation	0 1 2 3 4	59.	Difficulty with remembering words <input type="checkbox"/> L	0 1 2 3 4
42.	Need to look at someone's mouth when they are speaking to understand what they are saying	0 1 2 3 4	60.	Difficulty remembering numbers <input type="checkbox"/> L	0 1 2 3 4
43.	Difficulty in localizing sound	0 1 2 3 4	61.	Difficulty remembering to stay on time (reduced left) <input type="checkbox"/> L	0 1 2 3 4
44.	Dislike of left predictable rhythmic, repeated tempo and beat music <input type="checkbox"/> L	0 1 2 3 4	Occipital Lobe (Area, 17, 18, and 19)		Level
45.	Dislike of non-predictable rhythmic with multiple instruments <input type="checkbox"/> R	0 1 2 3 4	62.	Difficulty in discriminating similar shades of color	0 1 2 3 4
46.	Noticeable ear preference when using your phone	right, left, no preference	63.	Dullness of colors in visual field	0 1 2 3 4
Temporal Lobe Auditory Association Cortex (Area 22)		Level	64.	Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach out for objects	0 1 2 3 4
47.	Difficulty comprehending meaning of spoken words <input type="checkbox"/> L	0 1 2 3 4	66.	Floater or halos in visual field	0 1 2 3 4
48.	Tend toward monotone speech without fluctuations or emotions <input type="checkbox"/> R	0 1 2 3 4			

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Cerebellum - Spinocerebellum		Level		
67.	Difficulty with balance, or balance that is worse on one side	0 1 2 3 4	82.	Cramping of hands when writing
68.	A need to hold the handrail or watch each step carefully when going down stairs	0 1 2 3 4	83.	A stooped posture when walking
69.	Feeling unsteady and prone to falling in the dark	0 1 2 3 4	84.	Voice has become softer
70.	Proness to sway to one side when walking or standing	0 1 2 3 4	85.	Facial expression changed leading people to frequently ask if you are upset or angry
Cerebellum - Cerebrocerebellum		Level	Basal Ganglia Indirect Pathway	
71.	Recent clumsiness in hands	0 1 2 3 4	86.	Uncontrollable muscle movements
72.	Recent clumsiness in feet or frequent tripping	0 1 2 3 4	87.	Intense need to clear your throat regularly or contract a group of muscles
73.	A slight hand shake when reaching for something at the end of movement	0 1 2 3 4	88.	Obsessive compulsive tendencies
Cerebellum - Vestibulocerebellum		Level	Autonomic Reduced Parasympathetic Activity	
74.	Episodes of dizziness or disorientation	0 1 2 3 4	89.	Constant nervousness and restless mind
75.	Back muscles that tire quickly when standing or walking	0 1 2 3 4	90.	Dry mouth or eyes
76.	Chronic neck or back muscle tightness	0 1 2 3 4	91.	Difficulty swallowing supplements or large bites of food
77.	Nausea, car sickness, or seasickness	0 1 2 3 4	92.	Slow bowel movements and tendency for constipation
78.	Feeling of disorientation or shifting of the environment	0 1 2 3 4	93.	Chronic digestive complaints
79.	Crowded places cause anxiety	0 1 2 3 4	94.	Bowel or bladder incontinence resulting in staining your underwear
Basal Ganglia Direct Pathway		Level	Autonomic Increased Sympathetic Activity	
80.	Slowness in movements	0 1 2 3 4	95.	Tendency for anxiety
81.	Stiffness in your muscles (not joints) that goes away when you move	0 1 2 3 4	96.	Easily startled
			97.	Difficulty relaxing
			98.	Sensitive to bright or flashing lights
			99.	Episodes of racing heart
			100.	Difficulty sleeping

