Confidential Personal Information

Name: _____

Address: _____

City: _____ State: _____ ZIP _____

Phone (h): (_____) _____ Cell: (_____) _____

Phone (w): (_____) _____ Fax: (_____) _____

Email: _____

Employer: _____ Occupation: _____

Date of Birth: _____ / _____ / _____

Circle one: Married Single Divorced Widowed

Spouse/Domestic Partner: _____

_____

_____

Children, names & ages (oldest to youngest): _____

_____

_____

Comments: _____

_____

_____

_____

Client Questionnaire

Name: _____ Date: _____
Please feel free to use the back of the sheet or attach extra papers, if necessary to answer these important questions.

1. What symptoms exist that suggest a problem is occurring (body or mind / personal or business)?
   _____
   _____

2. What are the problems, fears, frustrations or concerns that exist because of those symptoms?
   _____
   _____

3. On a scale of 0 to 10, with 0 being Stress Free and 10 being extreme High Stress, what number would you assign the stress / pain when it is the worst?
   a. 0 – None 1 – Slight 2 – Mild 3 – Uncomfortable 4 – Disturbing – 5 Highly Uncomfortable 6 – Distressing 7 Increasingly Distressing 8 – Intense 9 – Extremely Intense 10 – Unbearable
   b. Yes No Does the same problem tend to occur?
   c. If so, is it Constant Frequent Intermittent
   d. Last time it occurred _____

4. What do you think the underlying cause of the above problems?
   _____

5. When did the problem start: _____

6. Were there any other events that occurred around the time of the onset of symptoms? (i.e. lost job, lost loved one) _____

7. What have you done so far to solve this problem? _____
   _____

8. List any recurring unpleasant or limiting thoughts or beliefs associated with these symptoms?
   _____
   _____

9. List any activities, things or people you avoid due to these symptoms?
   _____
   _____

10. Circle areas of life affected: Career Business Education Family
    Friends Financial Health Home Recreation Spiritual Purpose

11. Positive, yet unfulfilled thoughts or actions include: _____
    _____

12. What would your desired outcome look like? What would you be thinking / doing / feeling or believing different than you are now? _____
    _____

13. Vitamins, Herbs, Homeopathics or Medicine: _____
    _____

14. Please list any other relevant information. _____
    _____

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Listed below are some of our policies and fee information.

Thank you for choosing NET. The following rates apply for in-office consultations.
For on-site rates in Pennsylvania or California, please call the office.
In Office Rate (Fee due at time of visit).

$ 80.00	per 1/3 hour
$160.00	per 2/3 hour
$240.00	per 1 hour

For Hour Session of New Patient
The first twenty minutes of (the first) hour session is to establish if the consulting process is valuable in your situation. If either the doctor or the client chooses to terminate the visit at this point, there will be NO charge. If it is deemed beneficial by both the doctor and the client, the session will continue to the completion of the appointment. If there is a desire for more than one hour in a single session or a series of sessions, due to distance traveled or need for in-depth care, please call regarding this request. Thank you. Clients may take notes. The doctor may record the session for quality assurance.

Disclaimer
I understand that Dr. Strasburger's attempts to co-ordinate my body and nervous system are NOT the practice of psychology or psychiatry. If any other medical specialist or specialized form of consulting is indicated, it is understood a proper referral will be made. We do NOT guarantee results. Insurance coverage does not apply to these sessions as is true of most elective procedures.

I have read and agree with the above and acknowledge doing so by my signature.

Client's name: _____ Date: _____

Print Name: _____

(if applicable)
Parent/
Guardian: _____