No member of NSLB Inc. will ever ask for your sensitive medical information. No member of NSLB Inc. will ever ask for your social security number or bank account information.

Your medical information will be review by a qualified provider. This simple questionnaire is solely used as a reference.

Name: _____ Client Tracking Number _____

Afilliated branch of service:
- ☐ Army
- ☐ Marines
- ☐ Air Force
- ☐ Navy
- ☐ Coast Guard

Status:
- ☐ Active Duty
- ☐ Reserve/National Guard
- ☐ Discharged/Retired

How affiliated?
- ☐ Your Service
- ☐ Family Member's Service

Tour Dates:

Where: _____ Dates: _____

Where: _____ Dates: _____

Where: _____ Dates: _____

Where: _____ Dates: _____

Current Address: _____

Phone: _____ Cell
_____ Work
_____ Home

Email: _____

Emergency Contact: _____
Phone: _____ Relationship: _____
Do we have your permission to discuss your situation? ☐ Yes ☐ No

Best time to contact you:
Morning ☐ Mid afternoon ☐
Midday ☐ Evening ☐

Best way to contact you:
Phone Call ☐ Text ☐ Email ☐

Relationship Status: _____

Are you a parent? _____
Single parent? _____

How did you hear about NSLB?
Friend ☐ Website ☐
Family ☐ Other ☐ _____

Do you have a support system? _____
Do you have reliable transporation? _____
Are you working? _____
Are you in school? _____
Can you take five consecutive days off? _____
Can you take two hours off twice a week? _____
If no, how much can you take off? _____

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	Please check all that apply	You	A friend has	A family member has	A professional has
1	Has anyone ever told you that you have a TBI or PTSD?	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐
2	Do you get angry easily?	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐
3	Are you constantly "on guard"?	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐
4	Do you self medicate?	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐
5	Do you avoid crowds or crowded places?	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐
6	Do you sleep well?	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐
7	Do you constantly feel tired?	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐
8	Do you have trouble relaxing?	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐
9	Do you have problems staying focused on daily tasks?	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐
10	Have you ever tried any other treatment?	yes ☐ no ☐			
	What type?	Meds: yes ☐ no ☐	EMDR yes ☐ no ☐	Other yes ☐ no ☐	

If other, please list below

Please give us a short summary of why you need help and how you intend to help yourself in this process: