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& ASSOCIATES
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INTAKE/HISTORY INFORMATION FORM

First Name	MI	Last Name	Jr./Sr./II/III

Address________________________________ City______________ State______ Zip Code______________

Mobile # ( ) ______________ Landline # ( ) _______________ Work # ( ) _______________
Area Code Area Code Area Code

Email Address ____

Handedness: ____**R** ____**L** Date of Birth: ____/____/______

Parent or Guardian(s) of Minor information (complete as applicable)

Names(s) ____

Address________________________________ City______________ State______ Zip Code_______________

Mobile # ( ) ______________ Landline # ( ) _______________ Work # ( ) _______________
Area Code Area Code Area Code

Referral Source Information (if referred to this office by someone other than yourself)

____

Phone Number of Referral Source ( ) ____
Area Code

Physician/other Health Care Professional Information (chiropractor, therapist, naturopath, body worker, etc.)

Name____ Phone ( ) ______________________
Area Code

Diagnosis ____

Medication Information (complete as applicable)

Current Medications	Dose	When Taken	How Long

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

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____

What benefits do you hope to gain form neurofeedback?

____

____

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

Prenatal and Birth **Details**

- Prenatal stress of injury ☐ yes ☐ no _________________________
- Prenatal drug/alcohol exposure ☐ yes ☐ no _________________________
- Birth trauma (forceps, breach, etc.) ☐ yes ☐ no _________________________
- Anesthesia, pain, medications ☐ yes ☐ no _________________________
- Anoxia (oxygen deprivation at birth) ☐ yes ☐ no _________________________
- Premature/late delivery ☐ yes ☐ no _________________________
- Medical problems after birth ☐ yes ☐ no _________________________
- Other ____

Birth Weight ________
Adopted at age________

Growth and Development

	Typical	More	Less	Details
Activity Level				
Motor/coordination development				
Infections/allergies				
Emotional development				
Behavior concerns				
Handedness development				
Appetite/digestion				
Language/speech development				

- Head injury (even minor falls, etc.) ☐ yes ☐ no ________________________________
- Coma (loss of consciousness) ☐ yes ☐ no ________________________________
- Accidents (list all) ☐ yes ☐ no ________________________________
- High Fever ☐ yes ☐ no ________________________________
- Serious illness ☐ yes ☐ no ________________________________
- Surgery ☐ yes ☐ no ________________________________
- CNS infection ☐ yes ☐ no ________________________________
- Sexual abuse ☐ yes ☐ no ________________________________
- Physical abuse ☐ yes ☐ no ________________________________
- Emotional/Psychological abuse ☐ yes ☐ no ________________________________
- Drug overdose/poisoning ☐ yes ☐ no ________________________________
- Anoxia ☐ yes ☐ no ________________________________
- Stroke ☐ yes ☐ no ________________________________

Psychological Stress/Life Changes **Details**

- Death in family ☐ yes ☐ no ________________________________
- Divorce/remarriage ☐ yes ☐ no ________________________________
- Move/relocation ☐ yes ☐ no ________________________________
- School change ☐ yes ☐ no ________________________________
- Job change ☐ yes ☐ no ________________________________
- Family member chronic illness ☐ yes ☐ no ________________________________
- Alcoholism/drug addiction in family ☐ yes ☐ no ________________________________

Symptom Checklist

Please indicate if the **client** and/or **family member(s)** (parents, grandparents, brothers, sisters, aunts, uncles, and/or children) **currently experience (c),** or have a **history (H)** of any of the following symptoms.

Symptom	if client	if family	Symptom	if client	if family
Feeling Tense			Tremors		
Depressed			Suicidal ideas		
Always on the go			PMS		
School/work problem			Physical/sexual abuse		
Impulsivity			Over ambition		
Hyperactivity			Unable to relax		
Attention problems			Can't make decisions		
Behavior problems			Communication problems		
Vocal or motor tics			Problems at home		
Sleep problems			Financial problems		
Legal trouble			Any chronic illness		
Headaches					
Feeling anxious					

	client	family
Feeling lonely		
Frequent illness		
Repetitive thoughts		
Repetitive behaviors		
Shy with people		
Allergies		
Asthma		
Seizures		
Chronic pain		
Food sensitivity		
Head injury		
Memory problems		
Temper tantrums		
Rages		
Verbal Aggression		
Physical Aggression		
Stubbornness		
Addictions		
Bowel disturbances		
Chronic fatigue/FMS		
Inferiority feelings		
Dizziness		
Fainting spells		
Heart palpitation		
Stomach trouble		
Poor appetite		
Picky eater		
Nightmares		
Alcohol/drug problem		
Feeling panicky		

Any other symptoms not included in the list above (specify)____

____

Please list the **five current problems** listed above which are the **most distressing** to you or your child.

____

Therapist's comments:____

____

____

____

____

Therapist’s Signature

Date