NeuroIntegration Intake Form

PERSONAL INFORMATION

Name ____
Address ____
City ________________State ________Zip _______________
Email address _____________________________________

Date of birth ____/____/_____
Age ________years
Gender M F

Home Phone __________________________________
Work Phone __________________________________
Occupation __________________________________

Cell Phone __________________
Fax ________________________

Tell us more about your needs and desires regarding brain health.
How can we help? What are you hoping to address or achieve through our NeuroIntegration Program?

HEALTH INFORMATION

1. OVERALL HEALTH

On a scale of 1-10, how would you rate your current health? 1 2 3 4 5 6 7 8 9 10
(1 being the worst, 5 being average, 10 being the best)

2. SLEEP

Rate the quality of sleep you usually get in the past month. 1 2 3 4 5 6 7 8 9 10
At what time do you go to bed? ______________am/pm
At what time do you rise in the morning? ______________am/pm

Are you able to sleep through the night? YES NO
If NO, please describe:

Are you able to fall asleep easily most nights? YES NO
If NO, please describe:

Do you wake refreshed? YES NO
If YES, please describe any exceptions:

3. HEAD or NECK INJURY

Have you ever injured your head or neck?	YES	NO
Ever had a concussion?	YES	NO
If yes, have you suffered more than one concussion?	YES	NO
Have you ever been in an auto, motorcycle or bicycle accident?	YES	NO
Have you ever had a traumatic brain injury?	YES	NO
Are you currently receiving care for this/these injuries?	YES	NO

Please describe your head or neck injuries using the reverse side of this page, thinking back over the years. Please consider the childhood and teen years, as well as adulthood, including home life, sports, accidents, slips/falls, etc.

4. CHRONIC HEALTH PROBLEMS? Please list any chronic medical problems or brain health issues.

5. HORMONES

Are you concerned that hormonal imbalances that may be contributing to your condition? YES NO

6. MOODS & EMOTIONS

How would you describe your general emotional state? (A brief sentence or short phrase of 3-4 words is fine.)

7. **MEDICATIONS, SUPPLEMENTS & VITAMINS**

If you haven't previously listed these on our intake form, please provide a list here including name, dose, frequency and for what symptom you are taking each. Feel free to use the other side.

Medications	Nutrition Supplements/Vitamins

ANY KNOWN MEDICATION ALLERGIES?	YES	NO

Please list any medication allergies you may have:

8. **SUBSTANCES**

Do you currently use psychoactive drugs, medications or alcohol to pick yourself up or calm yourself down?	YES	NO
Have you ever used psychoactive drugs, medications or alcohol in the past to pick yourself up or calm yourself?	YES	NO
Are you currently a smoker?	YES	NO
Do you consider your current use of tobacco, alcohol or street drugs a problem?	YES	NO

If yes on any of these substances, circle those currently taking.

Do you feel depressed or anxious at the present time?	Depressed Neither	Anxious
Have you suffered from depression or anxiety in the past? Circle condition if yes.	YES	NO

9. **ATTENTION & LEARNING**

Any history of learning difficulties?	YES	NO
Any history of memory problems?	YES	NO
Any history of ADD/ADHD?	YES	NO

In childhood? Adulthood? (please circle)

10. **OTHER CONDITIONS**

Any history of other psychiatric conditions in yourself, such as schizophrenia, bi-polar disorder , psychosis?	YES	NO
Any history of other psychiatric conditions in family members, such as Schizophrenia, bi-polar, psychosis?	YES	NO

11. **COUNSELING & PSYCHOTHERAPY**

Are you currently working with a psychiatrist, therapist, counselor or clergy in matters regarding your mental health?	YES	NO

If yes, please list name/names______________________________

12. **SEIZURES or LIGHT SENSITIVITY?**

Are you, or have you ever been, sensitive to lights or strobe lights, had or been diagnosed with migraines or epileptic seizures?	YES	NO

13. **Is there anything that you would like to add?**

Parent or Guardian of Minor, please complete this section

Parent/Guardian Name ____

Address ____ City _____State ___Zip _____

Do you live with the patient? Y N Phone _________