NeuroIntegration Intake Form

PERSONAL INFORMATION

Name _____ Date of birth ____/____/_____
Address _____ Age _____years
City _____State _____Zip _____ Gender M F
Email address _____

Home Phone _____ Cell Phone _____
Work Phone _____ Fax _____
Occupation _____

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 you have on the back side of this form.

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 Anxious Neither

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 _____