VIRGINIA CENTER FOR NEUROFEEDBACK
ATTACHMENT & TRAUMA

Confidential Client Contact Information & Intake

Client Contact Information

Name: _____ Date of Intake: _____

Date of Birth._______________ Age: _____ Occupation (if applicable): _____

Preferred Phone for contact: _____ Alt. Phone: _____

Important: ***needed for billing*** - Address: _____

City, State & Zip: _____

Email:_____

Would you prefer paper invoices or e-invoices? Paper Invoices _____ e-Invoices _____

Emergency Contacts (Please list at least one)

1) Name: _____ Relationship: _____

Address: _____

Cell/Home Phone: _____ Work Phone: _____

2) Name: _____ Relationship: _____

Address: _____

Cell/Home Phone: _____ Work Phone: _____

Your reason for consultation right now?

_____

_____

_____

_____

_____

_____

Medical History

Primary Care Physician:_____ Phone: _____

Please list chronic illnesses or health conditions and treatment:

_____

_____

_____

_____

Are you taking any prescription or over-the-counter medication? Yes____ No ____

If yes, please indicate name of medicine and when you started it:

1) **Medication Name:** _____ Date Started: _____

Dosage:_____ To Treat:_____

2) **Medication Name:** _____ Date Started: _____

Dosage:_____ To Treat:_____

3) **Medication Name:** _____ Date Started: _____

Dosage:_____ To Treat:_____

4) **Medication Name:** _____ Date Started: _____

Dosage:_____ To Treat:_____

Do you smoke tobacco and if so, what type and how frequently?

_____

Do you drink/use caffeine, if so what type and how frequently?

_____

Do you drink alcohol, if so what type and how frequently?

_____

Do you any other drugs and if so, what type and how frequently?

_____

Might there be any reason to believe you have a problem with substance use? _____

Please indicate any hospitalizations:

Reason: _____ Date: _____

Reason: _____ Date: _____

Are you currently being treated for an emotional or medical condition? Yes____ No ____

If yes, please describe: _____

Have you ever had therapy, counseling or neurofeedback before? Yes____ No ____ If yes:

Therapist Name	Treatment Start/End Dates	Effective?

What do you do to maintain your health?

Please list significant illnesses in your family (For example; diabetes, cancer, head injury, heart problems, surgeries, emotional/psychiatric history, or substance abuse)

If you feel pain in your body, please describe the location(s) and sensation(s):

Additional medical information you'd like me to know at this time:

General Family Information

The following information may be helpful to your therapist in gaining additional understanding of your family system.

Please list everyone living with you currently:

Name	Relationship	Age	Gender	Job/School Grade

Family of Origin: List all members starting with your parents (guardians) and then add siblings. If a family member is deceased, please indicate their age at death under "Age" and under "Residence" list their date of death and the cause.

Name	Age	Gender	Occupation/School	Education Level	Residence

Partner's Family: Please list your partner first, and then your partner's parents and siblings. What is your date of marriage or union (if applicable)?

Name	Age	Gender	Occupation/School	Education Level	Residence

Your Children:

Name	Age	Gender	Occupation/School	Education Level	Residence