VIRGINIA CENTER FOR NEUROFEEDBACK
ATTACHMENT & TRAUMA

Contact Information

Name: ____Date of Intake: ________________________

Address: ______________________________________Email:________________________________

______________________________________SS#:________________________________

Date of Birth._____________ Age: ____ Occupation: ___________________________________

How would you like to receive your statement? [ ] digital [ ] paper

What is your preferred number for the receipt of phone messages?________________________

Please list those living in your home:

Name Relationship Age Gender Job/School Grade

____

____

____

Cell/Home Phone: _________________________ Work Phone: _______________________

Which number do you want me to use when calling about an appointment? _______________

Emergency Contacts (Please list at least one)

Name: _____________________________________ Relationship: ____________________________

Address: ____

Cell/Home Phone: ___________________________ Work Phone: ____________________________

Name: ____ Relationship: _______________________________

____

Address: ____

Cell/Home Phone: ___________________________ Work Phone: _______________________________

Medical History

Primary Care Physician: ____________________________ Phone: ________________________________

Please list chronic illnesses or health conditions and treatment: ______________________________

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____

Have you ever had a mild blow to the head? ____

Have you ever had a concussion with or without loss of consciousness?_______________________

____

____

Are you taking any prescription or over-the-counter medication? Yes_____ No _______

If yes, please indicate name of medicine, dosage, when you started it and the person who is prescribing it:

____

____

____

____

Robin C Bernhard, LCSW, MEd, BCN
bernhard.robin@gmail.com

420 Third Street, NE Charlottesville, VA 22902
P: (434) 825-6545 F: (800) 605-1939

Do you smoke? ________ What and how much? ____

Who else important to you smokes? ____

____

Do you drink caffeinated drinks? _________What and how many a day? _______________________

What alcoholic beverages do you drink? ____

When was your last drink? ______________How often do you drink? __________________________

When were you last drunk? _____________How often does that occur? ________________________

Might there be any reason to believe you have a problem with your drinking behavior? _______

Have you ever been hospitalized? Yes____ No ____ If yes, please list:

Reason: ____ Dates: _________________________

Reason: ____ Dates: _________________________

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:

Dates of treatment Therapist Name Effective?

____

____

____

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

Name	Issue	Medication	Medical Provider

What do you do to maintain your health? ____

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

____

Your reason for consultation right now? ____

____

____

____

____

If you feel pain in your body, please describe where, describe the sensation. What makes it better? What makes it worse? ____

____

____

____

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General Family Information

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	Marital	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	Marital	Occupation/School	Education Level	Residence

____

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Your Children:

Name	Age	Marital	Occupation/School	Education Level	Residence

For EMDR, you will be asked to complete a list of your 10 most disturbing memories during the intake interview. You may make a list before the meeting, but only if you are comfortable doing so.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________
10. ____________________