Confidential Client Contact Information and Intake

Client Contact Information

Name: ______________________ Date of Birth________________ Age: _____

Preferred Phone for contact: ______________________ Alt. Phone: ______________

Client mailing address: ____

City, State & Zip: ______________________ ☐ I prefer mailed paper invoices

Client Email: ____

☐ Please sign me up for e-invoices using the above email address
☐ Please sign me up to receive monthly Square invoices to pay via credit card

Emergency Contact

1) Name: ______________________ Relationship: ______________

Cell/Home Phone: ______________________ Work Phone: ______________

Your reason for consultation right now?

____

____

____

Please list any diagnoses of physical or mental illnesses:

____

____

____

Do you agree with these diagnoses? ☐ yes ☐ no ☐ uncertain

Medical History

Primary Care Physician: ______________________ Phone: ______________

Please list chronic illnesses or health conditions and treatment:

____

____

____

Please list all medications(attach list if preferred):

1) **Medication Name:** ____ Date Started: ________

Dosage:________________ Side Effects:____

Prescribed by:_______________________________________To Treat:___________________

2) **Medication Name:** ____ Date Started: _______

Dosage:________________ Side Effects:____

Prescribed by:_______________________________________To Treat:___________________

3) **Medication Name:** ____ Date Started: ________

Dosage:________________ Side Effects:____

Prescribed by:_______________________________________To Treat:___________________

4) **Medication Name:** ____ Date Started: _______

Dosage:________________ Side Effects:____

Prescribed by:_______________________________________To Treat:___________________

Please list any past medications and any side-effects you experienced from them (or attach list):

____

____

____

____

____

Do you ☐ smoke tobacco ☐ drink/use caffeine ☐ drink alcohol or ☐ use any other drugs
If you checked yes to any of the above, please describe usage frequency and details:

____

____

____

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

Please indicate any hospitalizations:

Reason: ________________________________ Date: ________________________________

Reason: ________________________________ Date: ________________________________

Do you have ☐ pain ☐ high or low blood pressure ☐ thyroid issues ☐ autoimmune problems ☐ memory problems ☐ headaches

If yes, please describe:

If you are currently being treated for an emotional or medical condition, please describe:

Have you ever had ☐ therapy or ☐ neurofeedback before?

Therapist Name	Treatment Start/End Dates	Effective?

Please list dates and reasons for any past brain imaging completed (MRI, CAT scan, EEG, QEEG).

List any significant impacts to the head, including whiplash injuries, falls that involved getting stitches on the head or face or resulted in medical attention.

Please check any of the following that you have a family history of:

☐ Mental Illness ☐ Stroke or Heart Attack before age 70 ☐ Seizures ☐ Thyroid ☐ Miscarriages

If you checked yes to any of the above, please identify the relative and provide brief details:

Modified Pittsburgh Sleep Quality Index (PSQI)

During the past month:

What time have you usually gone to bed at night? ____________________

How long (in minutes) has it usually taken you to fall asleep each night? ____________

What time have you usually gotten up in the morning? ____________________

Do you currently have trouble sleeping because of any of the following issues?

- ☐ Waking up in the middle of the night or too early in the morning
- ☐ Getting up to use the bathroom
- ☐ Cannot breathe comfortably
- ☐ Cough or snore loudly
- ☐ Feeling too cold
- ☐ Feeling too hot
- ☐ Having bad dreams
- ☐ Having pain

How often have you taken medicine to help you sleep (prescribed or over the counter)?

How often have you had trouble staying awake while driving, eating meals, or socializing?

How much of a problem has it been for you to keep up enough enthusiasm to get things done?

Have you ever had a sleep study? If so, when was that and what were the findings?

Have you been prescribed the use of C-PAP machine? If so, when and do you use it consistently?

Do you typically wake up feeling rested?