Client Information Form

Please fill in the information below and bring it with you to your first session. Please note: information provided on this form is protected as confidential information.

Personal Information

Name:_____ Date: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No

*Please note: email correspondence is not considered to be a confidential medium of communication.

Date of birth: _____ Age: _____ Gender: _____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced

□ Widowed □ Single

Please list the issue or issues, for which you are seeking help, and describe the frequency and severity of the symptoms and to what extent they interfere with your life:

_____

_____

History

Have you previously received any type of mental health services?

_____

If yes, please list your previous therapist(s) and/or practitioner(s):

_____

Are you currently taking any prescription medication? _____ If yes, please list:

_____

_____

_____

Have you ever been prescribed psychiatric medication? _____ If yes, please list and provide dates:

_____

_____

General and Mental Health Information

Please list any specific health problems you are currently experiencing:

_____

Please list any specific, significant health issues of the past:

_____

Have you ever been involved in a motor vehicle, motorcycle, or bicycle accident?

_____

If so, please describe how it affected you (were you injured, etc.) and, possible aftereffects and treatments you received:

_____

Have you ever experienced any form (including a motor vehicle accident) of a neurological trauma (head injury, loss of consciousness, stroke, concussion, or anything you feel might relate to such an issue)?

_____

_____

Have you ever experienced a seizure? _____ If so, please describe when it happened, how many times it has happened, and what treatments you have received to treat the seizure(s):

_____

Do you (or have you) experience(d) ringing in your ears? _____ If so, please describe when you noticed it and the frequency and duration of this symptom:

_____

_____

Are you currently experiencing migraine or other severe headaches? _____ If so, please describe how long you have been experiencing this, if there are any factors that seem to bring on the headaches, and if there is anything that seems to relieve the pain/pressure:

_____

Have you ever experienced an event that caused significant emotional trauma (e.g. PTSD), such as witnessing a death or a traumatizing physical injury or experiencing threat to your life?

_____

If so, please give a very brief summary of the event and when it happened:

_____

Are you experiencing chronic pain? If so, rate your current level of pain: _____

If applicable, please describe where you are feeling the pain and the medical treatments that you have received: _____

_____

Please describe your current sleep pattern (time to bed, time arising, intermittent awakenings etc.) and any other specific problems you have with sleep:

_____

_____

Please list any difficulties you experience with your appetite or eating problems:

_____

Are you currently experiencing sadness, grief or depression? □ No □ Yes

If yes, please describe how often you are feeling depressed, how long you have been feeling depressed, and any treatments you have received for depression:

_____

_____

Have you ever experienced the desire to kill yourself or harm yourself? _____

If so, please list how recently you experienced such thoughts:

_____

Are you currently experiencing anxiety (e.g. feeling worried, nervous, tense, fearful, or overwhelmed)?

_____

If yes, please describe how often you are feeling anxious, how long you have been feeling anxious, and any treatments you have received for anxiety:

_____

_____

Do you experience significant frustration or anger? _____ If so, please describe how often this is an issue for you and the seriousness of these symptoms in your life:

_____

_____

Please list the frequency and amount of your use of alcohol (if you do not drink, list "N/A"):

_____

Please list the frequency and amount of use of other substances that may be used (e.g. marijuana):

_____

Please list any significant life changes or stressful events that you have recently experienced:

_____

_____

Family Mental Health History

Please list family (blood relatives) who have been treatment by mental health professionals, or who have experienced mental health distress (e.g. depression, anxiety, bipolar disorder, suicidal ideas, substance abuse):

_____

_____

Additional Information

What is your level of education?

_____

Have you ever been diagnosed or treated for Attention deficit disorder, dyslexia, or a learning disability (or do you believe that you experience difficulties in any one or more of these areas, even if you have not received a diagnosis or treatment)?

_____

If you are employed, please list the nature of your job and how long you have been performing it:

_____

Please describe your current living situation and who you confide in, or look to for emotional support:

_____

_____

Are there any religious or other preferences that are important to you that you would like to share?

If so, please list them here:

_____

How did you hear about neurofeedback?

_____

What are your expectations about what you are hoping to accomplish as a result of neurofeedback treatment?

_____

_____

How did you become aware of our services?

_____

Do you have any questions about neurofeedback? _____ If so, please list them below so that we can help you:

_____

_____