Performance Health, P.A.

PT INTAKE

1. CLIENT INFORMATION

Name: ____ Date: ______________
E-Mail: ____
Age: ____________________________ Circle: Male or Female
Birth Date: ____

Circle: Single Married Engaged Separated Divorced Widowed
Living w/ sig other
If married, length of marriage: ___________ Number of Children: _____________

Home Address: ____
Street

____
City State Zip
Home Phone: _____________________________Is it OK to leave a message? _____
Work Phone: _____________________________ Is it OK to leave a message? _____

Occupation: _______________________________

Who referred you here or how did you hear about us? ________________________
Person to contact in case of emergency: _____________________________________
Relationship: ____________________________ Phone: ________________________

2. PRESENTING PROBLEMS (why are you here?) DATES BEGAN: SEVERITY w/ scale of 1-10 & 10 is worst

1. ____
2. ____
3. ____
4. ____

3. CLIENT GOALS

What are your goals here?

____
____
____

What would changes look like in life?

____
____
____

How do you expect to benefit from Neurofeedback?
____
____
____

4. COUNSELING/ THERAPY/ PSYCHIATRIC TREATMENT HISTORY

Are you currently under another therapists care? ______________________________
If so, Name: ____
Phone Number: ____
Describe purpose: ____
Name of Primary Care Physician: ____
Have you had previous treatment under another counselor/ therapist? _________
How long ago? ____
Describe purpose: ____
____

5. CURRENT MEDICAL HISTORY

Primary Physicians Name: ____
Date of last physical exam: ____

Are you currently under one or more doctor's care? ______________
If so, please list purpose: ____
____

6. CURRENT MEDICATIONS

What medications are you currently taking?	Purpose:	Start Date:	Dose:	How often?
1. ____________	____________	____________	____________	____________
2. ____________	____________	____________	____________	____________
3. ____________	____________	____________	____________	____________
4. ____________	____________	____________	____________	____________
5. ____________	____________	____________	____________	____________
6. ____________	____________	____________	____________	____________
7. ____________	____________	____________	____________	____________

Who is the prescribing Physician? ____
Are you allergic to any medications? ____________
If yes, which ones? ____

Blood pressure: ____________________________________ Pulse: ________________________

7. HISTORY OF PAST OR CURRENT ILLNESS OR INJURY:

How often & Dates

Allergies ____
Asthma ____
Cancer ____
Cardiac or Heart problems ____
Convulsions ____
Diabetes ____
Epilepsy ____
Headaches ____
Head Concussions ____
High or Low Blood Pressure ____
Hypoglycemia or Hyperglycemia ____
Kidney Disease ____
Liver Disease ____
Lung Disease ____
Migraines ____
Schizophrenia ____
Seizures ____
Strokes ____
Sleep Disorders ____
Tuberculosis ____
Ulcers ____
Other ____

Major health problems of blood related mother & father:
____
____

Major health problems of blood related grandparents:
____
____

Major health problems of blood related siblings, aunts, uncles, & cousins:
____
____

8. DRUG & ALCOHOL HISTORY

Current: None ______________ Abuse _______________ Dependence _________________

Substances: ____
Quantity: ______________________________ Frequency: _______________________________
For how long: ____________________________ Date last used: ________________________
# of attempts at sobriety: _________________________

Do you smoke tobacco? ____________________ Marijuana? __________________________
Amount: ________________________How long? _______________________________________

Do you use caffeine? ______________ Amount: ______________How long? _____________

Past: None ________________ Abuse ______________ Dependence _______________
Substances: ____
Quantity: _______________________________ Frequency: _______________________________
For how long: ____________________________ Date last used: _______________________
# of attempts at sobriety: __________________________

Do you have any previous treatment for drugs or alcohol? (Check all that apply)
_____ Outpatient CD Support _____Inpatient Psychiatric
_____ Self-help Group _____ Outpatient Psychiatric (Psychotherapy)
_____ Psychotropic Medication Management _____ Inpatient CD _____ None
_____ Other: ____

If any are marked above, please give dates of treatments: ________________________
____

List any family members, and their relationship to you, who abuse alcohol &/or drugs. List substances & when: ____
____
____

9. FAMILY HISTORY

_____ ETOH abuse/ dependence _____ Suicide attempts _____ Divorce
_____ Drug abuse/ dependence _____ Mood disorders
_____ Other psychiatric problems _____ Emotional abuse

If any are marked above, please explain: ____
____

10. SELF IMAGE

What is your self-image right now?
Physically: ____
Emotionally: ____

Spiritually: ____
Mentally: ____
Other: ____

11. SUICIDAL IDEATION

Have you ever attempted suicide? __________
If yes, when, how, & why? ____________________________________
____

Do you currently have any thoughts of suicide? ___________
If yes, explain: ____
____
____
If yes, do you have a plan and means? ___________
If yes, describe and explain: __________________________________
____
____

Has anyone in your family committed suicide? ____________
Who, when, how, & why? _____________________________________
____
____

Do you have any thoughts of homicide? ____________
If yes, who? ____
If yes, is there a plan, method, and means? Please describe: _______________
____
____

12. FAMILY OF ORIGIN (PARENTS)

Who were you raised by? ____________________________________

(Name? Age? Still Married? Divorced? Where Living? Passed Away? When? Cause?)

Father: ____
____
Mother: ____
____

Siblings: ____
____
____
____

Nature of your relationship with them: ________________________________
____

13. CURRENT FAMILY (NOT PARENTS)

Name Age Living at home?

Spouse or companion (circle): ____
Child: ____
Child: ____
Child: ____
Other: ____

Nature of your relationship with them: ________________________________
____

Please use the back of this page to write in any other important health considerations you may have.

AGREEMENT
I consent to Neurofeedback Therapy at Performance Health, P.A. and the software used for Neurofeedback: BrainPaint, Thought Technology, Brain Master.
I understand that I am financially responsible for payment.

_______________________________________ ____________________
Print Name of Client **Date**

____
Signature of Client (If client is under the age of 18, print name of parents or guardian and relationship)

____
Signature of Parents or Guardian