Would you like to receive a copy of your visit statements?
☐ Yes ☐ No
If yes, weekly or monthly?
☐ Weekly ☐ Monthly

BRAINPAINT INTAKE FORM

DATE_______________

CLIENT NAME__________________________ DOB__________ AGE_______ M / F SSN______________

ADDRESS____ CITY_________________ ZIP_____________

PHONE NUMBER______________________ H W C EMAIL ADDRESS ____________________________

PROFESSION_________________________________ EMPLOYER_________________________________

RELIGION/CHURCH (IF ANY)__________________ ETHNICITY/COUNTRY OF ORIGIN_________________

NAME OF PARENT OR SPOUSE____

PARENT/SPOUSE CONTACT NUMBER________________________ H W C

IF YOU ARE HERE FOR YOUR CHILD, WHO HAS CUSTODY? ______________________________________

WHO REFERRED YOU?

HAVE YOU HAD COUNSELING, PSYCHOTHERAPY OR NEUROFEEDBACK BEFORE?

ARE YOU ON MEDICATION FOR A PSYCHIATRIC DISORDER? (IF YES, PLEASE LIST MEDICATIONS)

IS THERE A FAMILY HISTORY OF PSYCHIATRIC DISORDERS OR MOOD DISORDERS?

MEDICAL HISTORY:

HAVE YOU HAD A HEAD INJURY?

SUBSTANCE ABUSE HISTORY:

WHY ARE YOU SEEKING BRAINPAINT NEUROFEEDBACK AT THIS TIME?

Fonda Hart, LMFT • CA License LMFT39053
6042 N. Fresno Street, Suite 101, Fresno, CA 93710
Phone: (559) 801-1430 • FondaHart@FresnoCounseling.com