

BRAINPAINT INTAKE FORM

Would you like to receive a copy of your visit statements?

Yes No

**Visit statements are Emailed on a monthly basis, please provide your Email below.*

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?