

# NeuroIntegration Intake Form

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## PERSONAL INFORMATION

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email address \_\_\_\_\_

Date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Age \_\_\_\_\_ years  
Gender M \_\_\_\_\_ F \_\_\_\_\_

Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Occupation \_\_\_\_\_

Cell Phone \_\_\_\_\_  
Fax \_\_\_\_\_

### Tell us more about your needs and desires regarding brain health.

How can we help? What are you hoping to address or achieve through our NeuroIntegration Program?

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## HEALTH INFORMATION

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### 1. OVERALL HEALTH

On a scale of 1-10, how would you rate your current health? 1 2 3 4 5 6 7 8 9 10  
(1 being the worst, 5 being average, 10 being the best)

### 2. SLEEP

Rate the quality of sleep you usually get in the past month. 1 2 3 4 5 6 7 8 9 10  
At what time do you go to bed? \_\_\_\_\_ am/pm  
At what time do you rise in the morning? \_\_\_\_\_ am/pm

Are you able to sleep through the night? YES NO  
If NO, please describe:

Are you able to fall asleep easily most nights? YES NO  
If NO, please describe:

Do you wake refreshed? YES NO  
If YES, please describe any exceptions:

### 3. HEAD or NECK INJURY

Have you ever injured your head or neck? YES NO  
Ever had a concussion? YES NO  
If yes, have you suffered more than one concussion? YES NO  
Have you ever been in an auto, motorcycle or bicycle accident? YES NO  
Have you ever had a traumatic brain injury? YES NO  
Are you currently receiving care for this/these injuries? YES NO

Please describe your head or neck injuries using the reverse side of this page, thinking back over the years. Please consider the childhood and teen years, as well as adulthood, including home life, sports, accidents, slips/falls, etc.

### 4. CHRONIC HEALTH PROBLEMS?

Please list any chronic medical problems or brain health issues you have on the back side of this form.

### 5. HORMONES

Are you concerned that hormonal imbalances that may be contributing to your condition? YES NO

### 6. MOODS & EMOTIONS

How would you describe your general emotional state? (A brief sentence or short phrase of 3-4 words is fine.)

**7. MEDICATIONS, SUPPLEMENTS & VITAMINS**

If you haven't previously listed these on our intake form, please provide a list here including name, dose, frequency and for what symptom you are taking each. Feel free to use the other side.

Medications

Nutrition Supplements/Vitamins

ANY KNOWN MEDICATION ALLERGIES?

YES

NO

Please list any medication allergies you may have:

**8. SUBSTANCES**

Do you currently use psychoactive drugs, medications or alcohol to pick yourself up or calm yourself down?

YES

NO

Have you ever used psychoactive drugs, medications or alcohol in the past to pick yourself up or calm yourself?

YES

NO

Are you currently a smoker?

YES

NO

Do you consider your current use of tobacco, alcohol or street drugs a problem?

YES

NO

If yes on any of these substances, circle those currently taking.

Do you feel depressed or anxious at the present time?

Depressed  
Neither

Anxious

Have you suffered from depression or anxiety in the past?  
Circle condition if yes.

YES

NO

**9. ATTENTION & LEARNING**

Any history of learning difficulties?

YES

NO

Any history of memory problems?

YES

NO

Any history of ADD/ADHD?

YES

NO

In childhood? Adulthood? (please circle)

**10. OTHER CONDITIONS**

Any history of other psychiatric conditions in yourself, such as schizophrenia, bi-polar disorder, psychosis?

YES

NO

Any history of other psychiatric conditions in family members, such as Schizophrenia, bi-polar, psychosis?

YES

NO

**11. COUNSELING & PSYCHOTHERAPY**

Are you currently working with a psychiatrist, therapist, counselor or clergy in matters regarding your mental health?

YES

NO

If yes, please list name/names \_\_\_\_\_

**12. SEIZURES or LIGHT SENSITIVITY?**

Are you, or have you ever been, sensitive to lights or strobe lights, had or been diagnosed with migraines or epileptic seizures?

YES

NO

**13. Is there anything that you would like to add?**

**Parent or Guardian of Minor, please complete this section**

Parent/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Do you live with the patient? Y N Phone \_\_\_\_\_