NEUROFEEDBACK SERVICES OF NEW YORK, PC
140 West 79th St. Suite 2B, NY, NY 10024 (212) 877-7929
neurofeedbackservicesny@gmail.com

NEW CLIENT INFORMATION FORM

(Please complete all forms)

Date: _____

Name: _____
(Last) (First) (Middle)

Client Address: _____

City/State/Zip: _____

Date of Birth: _____ **Age:** _____

Home Phone: _____ **Cell:** _____

Business Phone: _____

Email: _____

In case of emergency contact: _____

Relationship Status: _____ **Partner's Name:** _____

Children's Names/Ages: _____

Mother's Name: _____

Father's Name: _____

_____

Names and ages of siblings and any live-in relationships:

_____

_____

Occupation: _____

Referral Source: _____

Handedness: L R

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School _____ **Grade:** _____

Address: _____

Teachers _____

Hobbies, Sports, Special Interests & Skills _____

_____

Please indicate with an "X" if any of the following symptoms have been exhibited by <u>the client</u> within the past 12 months. If a symptom is serious please indicate that symptom with a double XX

_____ **Headaches**	_____**Increased moodiness**
_____**Digestive Problems**	_____**Withdrawal from other people**
_____**Insomnia**	_____**Difficulty concentrating**
_____**Loss of Memory**	_____**Rashes or other skin problems**
_____**Sexual difficulties**	_____**Increased restlessness**
_____**Hypertension**	_____**Difficulty making decisions**
_____**Chest pain**	_____**Annoyed by little things**
_____**Heart palpitations**	_____**Shy or overly sensitive**
_____**Loss of appetite**	_____**Frequent crying**
_____**Always hungry**	_____**Considered suicide**
_____**Neck spasms**	_____**Fear of criticism**
_____**Muscle spasms**	_____**Angers easily**
_____**Chronic fatigue**	_____**Nightmares**
_____**Jaw pain**	_____**Hopeless outlook**

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_____**Dizzy spells**	_____**Finger tapping**
_____**Foot tapping**	_____**Finger tapping**
_____**Nausea**	_____**Frequent urination**
_____**Compulsive eating**	_____**Body warm or cold**
_____**Nail biting**	_____**Repetitive thinking**
_____**Night sweats**	_____**Constant perspiration**
_____**Increased smoking**	_____**Increased alcohol consumption**
_____**Increased drug use**	_____ **Increased smoking**
_____**Work absence or lateness**	_____**Non-stop talking**

Reason(s) for doing EEG Biofeedback

_____

_____

_____

History of Vision, Hearing, Speech or Emotional Problems

_____

_____

_____

Medical Problems

_____

_____

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Illnesses or significant stresses in the past year

_____

_____

_____

Minor's Physician _____

Address _____

Caffeine Consumption (coffee, tea, chocolate, colas)
Number of containers & ounces per container _____

Use of tobacco (if applicable) ___Yes ____ No Comment _____

Use of Alcohol or drugs ___Yes ___No Comment _____

Parents reasons for seeking assessment or treatment

FAMILY HISTORY

Please indicate by a CHECK MARK whether a member of the client's immediate family has, or had, any of the following conditions. Immediate family is defined as Mother, Father, Grandparents and siblings. If information is unknown (ex. Adoption) please tell the intake therapist.

_____**Allergies**	_____**Migraine Headaches**
_____**Motor or Vocal Tics**	_____**Asthma**
_____**Muscle Tension Headaches**	_____**Hyperactivity**
_____**Arthritis**	_____**Manic/Depression**

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_____Addiction Disorder **_____Diabetes**

_____Panic Attacks **_____Sleep Disorder**

_____Colitis **_____ Speech Disorder**

_____Thyroid **_____Eating Disorder**

_____ Learning Disorder **_____Phobias**

_____Anti-social Behavior **_____Language Disorder**

_____Obesity **_____English Second Language**

_____Seizures **_____Anxiety**

_____ADD **_____ ADHD**

Please list any other diagnosis that may be in the family that is not listed above:

_____

_____

_____

Client Information

Please list names, addresses (and phone numbers of physicians, therapists, or other practitioners presently being seen:

1. _____

2. _____

3. _____

4. _____

5. _____

Please list all the medications, vitamins, etc. the CLIENT is taking.

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1. _____

2. _____

3. _____

4. _____

5. _____

Who diagnosed the client: _____

At what age? _____

Has the client ever had a QEEG or brainmap? _____

Name of Physician _____

Comments:

_____

_____

_____

Have you been in an accident of any kind (car, fall down, head trauma, etc.) within the past year? (please explain):

_____

_____

_____

Date of Accident _____

Have you been in an accident of any kind within the past (5) years or more? (please explain):

_____

_____

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_____

_____

Date of Accident _____

Please list any symptoms you have which are not listed above:

_____

_____

_____

Comments:

_____

_____

_____

Signature of person completing form: _____