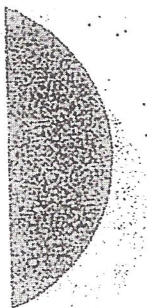

Brain Health Center

3100 Route 138 West
Building 3, Suite 1
Wall Township, NJ 07719

848-404-9111
www.brainhealthcenter.com

NEW CLIENT INFORMATION FORM

(Please print and complete all forms)

Handedness: ____ Left ____ Right

Date: ____________________

Name: ____
(Last) (First) (Middle)

Social Security # ____________________ Date of Birth: ______________ Age: __________

Client Address: ____

City/State/Zip: ____

May we have permission to mail to above address? Yes _____ No _____

Home #: ____________________ Cell #: ____________________

Work #: ____________________ Ok to leave message on: ____ Home ____ Cell ____ Work

Email: ____

In case of emergency contact: ____

Emergency contact's phone: ____

Parent(s) or Guardian(s) of Minor:

____
Name Relationship to client

____
Address

____
City State Zip

____
Cell # Home#

Others living in the home: (including children)

Name	Age	Relationship to client
1.		
2.		
3.		
4.		
5		

Client's School: ______________________________

Grade: ______________ IEP: _____ Yes _____ No

Please describe why you are here today:

____

____

____

What benefits do you hope to get from counseling and/or neurofeedback training?

____

____

____

Have you ever been diagnosed with any of the following? (Please circle)

ADD	SEIZURE DISORDERS SUCH AS EPILEPSY	ALZHEIMER'S
ADHD	DEPRESSION	COGNITIVE IMPAIRMENT
TRAUMATIC BRAIN INJURY	BIPOLAR DISORDER	STROKE OR TRANSIENT ISCHEMIA
ANXIETY	TOURETTE'S	POST TRAUMATIC STRESS DISORDER
SLEEP DISORDER	MIGRAINES	ASTHMA
IRRITABLE BOWEL	ALLERGIES	CHRONIC PAIN
HEART ATTACK	HEART DISEASE	OBSESSIVE COMPUSLIVE DISORDER
FIRBOMYALGIA	REFLEX SYMPATHETIC DYSTROPHY (RSD)	HIGH BLOOD PRESSURE
MEMORY IMPAIRMENT	ASPERGERS	AUTISM

Who diagnosed your condition(s), what is their profession and how old were you at time of diagnosis?

Name	Profession	Condition	Age

Medication/Dosage	Prescriber	Date Prescribed

Please list all current supplements, vitamins, etc.

____

____

____

Please describe any type of behavioral mental health services, including psychiatric, obtained currently or in the past.

____

____

____

____

____

____

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

____

____

____

Date of Accident: ______________________________

Have you been in an accident of any kind (car, fall down, head trauma, etc.) within the past 5 years or more?
Please explain below:

____

____

____

Date(s) of Accident: ______________________________

____

Current and History of Medical Problems: ______________________________

____

Illnesses or significant stressors in the past year: ______________________________

____

____

Daily Caffeine Consumptions ______________________________

____

Use of Nicotine: _____ Yes _____ No Comments: ______________________________

____

Use of Alcohol: _____ Yes _____ No Use of recreational drugs: _____ Yes _____ No

Comments: ______________________________

____

Developmental History—Please indicated your history in relation to the following:

Prenatal and Birth	Yes	No	Comments:
Prenatal stress or injury	___	___	___
Prenatal drug/alcohol exposure	___	___	___
Birth trauma (forceps, breech, etc.)	___	___	___
Anesthesia, pain medications	___	___	___
Anoxia (oxygen deprivation @ birth)	___	___	___
Premature/late delivery	___	___	___
Medical problems after birth	___	___	___
Birth weight: ___	___	___	___
Adopted at age: ___	___	___	___
Other ___			___

Psychological Stress/Life Changes	Yes	No	Comments:
Death in family	___	___	___
Divorce/remarriage	___	___	___
Move/relocation	___	___	___
School change	___	___	___
Job change	___	___	___
Family member chronic illness	___	___	___

Physical Traumas	Yes	No	Comments:
Head injury (even minor falls, etc.)	___	___	___
Coma (loss of consciousness)	___	___	___
Accidents (list all)	___	___	___
High fever	___	___	___
Serious illness	___	___	___
Surgery	___	___	___
CNS infection	___	___	___
Drug overdose/poisoning	___	___	___
Recreational drug use	___	___	___
Anoxia (absence of oxygen)	___	___	___
Stroke	___	___	___

Growth and development	Typical	More	Less	Comments:
Activity Level	___	___	___	___
Motor/Coordination development	___	___	___	___
Infections	___	___	___	___
Allergies	___	___	___	___
Emotional development	___	___	___	___
Behavior concerns	___	___	___	___
Handedness development	___	___	___	___
Appetite/digestion	___	___	___	___
Language/speech development	___	___	___	___

Symptom Checklist

Please indicate "C" or "H" if the client and or **family member(s)** (parents, grandparents, brother, sisters, aunts, uncles, and/or children) **currently experience "C"** or have a **history "H"** of any of the following symptoms.

Symptom	if client	if family
Feeling tense	____	____
Depressed	____	____
Always on the go	____	____
School/work problem	____	____
Impulsivity	____	____
Hyperactivity	____	____
Attention problems	____	____
Behavior problems	____	____
Vocal or motor tics	____	____
Sleep problems	____	____
Legal trouble	____	____
Headaches	____	____
Temper tantrums	____	____
Rages	____	____
Verbal aggression	____	____
Physical aggression	____	____
Stubbornness	____	____
Addictions	____	____
Bowel disturbances	____	____
Chronic Fatigue	____	____
Inferiority feelings	____	____
Dizziness	____	____
Fainting spells	____	____
Heart palpitations	____	____
Stomach trouble	____	____
Picky eater	____	____
Nightmares	____	____

Symptom	if client	if family
Feeling lonely	____	____
Frequent illness	____	____
Repetitive thoughts	____	____
Repetitive behaviors	____	____
Shy with People	____	____
Allergies	____	____
Asthma	____	____
Seizures	____	____
Chronic pain	____	____
Food sensitivity	____	____
Head injury	____	____
Memory problems	____	____
Feeling panicky	____	____
Tremors	____	____
Suicidal ideas	____	____
PMS	____	____
Physical/sexual abuse	____	____
Over ambitious	____	____
Unable to relax	____	____
Can't make decisions	____	____
Communication problems	____	____
Problems at home	____	____
Financial problems	____	____
Any chronic illness	____	____
Poor appetite	____	____
Eating disorders	____	____
Alcohol/drug problem	____	____

Other (specify): ____

Comments: ____

____

____

____