New Patient Intake Form

The Brain Gym
970-665-9956
110 E 3rd St Ste209, Rifle CO

Micro Current Neurofeedback Assessment and Medical History

Please note: This is an extensive form and may take 10 to 20 minutes to complete.

1. Where did you hear about The Brain Gym

2. PAST Medical History:
   Please list any PAST illness, diagnosis, physical injury, or head injury - brain injury / concussion / whiplash / falls / surgeries

3. PRESENT Medical History:
   Please list any PRESENT illness, diagnosis, physical injury, or head injury - brain injury / concussion / whiplash / falls / surgeries

Medications and Supplements

Please list all medications or supplements you are taking along with the dosage and reason for taking.

4. Medication - Dose - Reason for taking.

Allergies - Food or Environmental

Please list any allergy and your reaction from exposure.

5. Allergy - Reaction *

Personal History

6. Medical Conditions Please check all that apply.

- [ ] Autoimmune
- [ ] Cancer
- [ ] Diabetes
- [ ] Heart Disease
- [ ] Lung Disease
- [ ] Mental illness
- [ ] Thyroid
- [ ] None
- [ ] Other: Please describe below

7. Have you ever had ECT? *

- Yes
- No

Social History

Please select Current, Past, or Never used

8. Alcohol ◯ Current ◯ Past ◯ Never
9. Smoking ◯ Current ◯ Past ◯ Never
10. Steroids ◯ Current ◯ Past ◯ Never
11. Antacids ◯ Current ◯ Past ◯ Never
12. Laxatives ◯ Current ◯ Past ◯ Never
13. Pain Meds ◯ Current ◯ Past ◯ Never
14. Addiction ◯ Current ◯ Past ◯ Never
15. If you have/had an addiction please list treatment.

____

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Emotional History

16. Anxiety ◯ Current ◯ Past ◯ Never
17. Panic ◯ Current ◯ Past ◯ Never
18. Depression ◯ Current ◯ Past ◯ Never
19. Irritability ◯ Current ◯ Past ◯ Never
20. Abuse History ◯ Current ◯ Past ◯ Never
21. Insomnia ◯ Current ◯ Past ◯ Never
22. High Strung ◯ Current ◯ Past ◯ Never
23. Food Addiction ◯ Current ◯ Past ◯ Never
24. Suicidal ◯ Current ◯ Past ◯ Never
25. Fear ◯ Current ◯ Past ◯ Never
26. Eating Disorder ◯ Current ◯ Past ◯ Never
27. PTSD ◯ Current ◯ Past ◯ Never
28. Guilt ◯ Current ◯ Past ◯ Never

Review of Symptoms

29. How often do you have Headaches? ◯ Never ◯ Occasionally ◯ Constantly

30. Where are your headaches usually located? ____________________

31. What is the severity of pain? 0=No pain, 10=worst pain ever __________

32. History of Migraine headaches?If so, Please indicate triggers.

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33. Please Check all the conditions that apply. *Check all that apply.*

- [ ] Fibromyalgia
- [ ] Photophobia (sensitivity to light)
- [ ] Hyperacusis (sensitivity to or pain from sound)
- [ ] None

34. Do you have Body, Joint, or Limb pain? If so, please describe.

____

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35. Please describe what makes your pain BETTER

____

____

____

36. Please describe what makes your pain WORSE

____

____

____

Sleep

37. Select all that apply. *Check all that apply.*

- [ ] Difficulty FALLING asleep
- [ ] Difficulty STAYING asleep
- [ ] Wake NOT feeling rested
- [ ] None

38. How many hours do you sleep per night? ______________

39. How many hours of sleep do you feel you need? ______________

40. ADD / ADHD ( ) Yes ( ) No

41. Medication or treatment for ADD / ADHD

____

42. Please check all that apply.

- [ ] Poor concentration
- [ ] Impulsivity
- [ ] Difficulty making decisions
- [ ] Easily distracted
- [ ] Racing thoughts
- [ ] Disorganized
- [ ] Overwhelmed by stimuli
- [ ] None

Neurological Issues

43. Please select all that apply.

- [ ] Seizures
- [ ] Stroke
- [ ] Tremors
- [ ] Traumatic Brain Injury
- [ ] Vertigo
- [ ] Tinnitus (ringing in the ears)
- [ ] Hearing Loss
- [ ] Poor Balance
- [ ] None

Immune, Endocrine, Autonomic Nervous System

44. Please select all that apply.

- [ ] Immune Deficiency
- [ ] Adrenal Insufficiency
- [ ] Chronic Fatigue Syndrome
- [ ] Constipation
- [ ] Irregular Menstrual Periods
- [ ] Premenstrual Syndrome (PMS)
- [ ] Menopause
- [ ] None

Gut Health

45. Please select all that apply

- [ ] Constipation
- [ ] Loose Stool
- [ ] Gas
- [ ] Bloating
- [ ] None

46. Bowel Movement at least once a day?

( ) Yes ( ) No

47. Do food sensitivities make it worse?

( ) Yes ( ) No

48. Please describe other Stomach/ Digestion Issues.

Pre-Session Preparation

Please come into your sessions without lotions or substances on your skin on your face, neck and forehead.

Do not plan to have any other treatments such as massage, dental work, chiropractic work, or therapy sessions on the same day as your MCN treatment.

Please know that drinking alcohol the day of your treatment can also hinder progress and avoid drinking on the day of your treatment.

To the Best of My Knowledge the above information is correct.

Name

____

Date

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Example: January 7, 2019