

RESILIA NEUROTHERAPY SERVICES

CLIENT INTAKE

GENERAL INFORMATION:

NAME _____ AGE _____ DATE _____

Treating Physician _____ Phone #: _____

Referring Practitioner: _____ Phone #: _____

REASON FOR THIS APPOINTMENT:

What brings you in today? _____

Please describe any symptoms you're having. Intensity (0-10, with 0 being healthy and 10 being the worst)

Symptom	Intensity (rate from 0-10, with 10 being the worst)	How often do you get the symptoms? (ex. 1x a week)	How long do the symptoms last? (ex. 2 hours)

What other approaches have you sought out in the past to address the issues presented above and/or to achieve your goals of what you hope to accomplish with this therapy?

Have you had any major life changes, surgeries, serious injuries, or illnesses in the last five years?

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

Name: _____ Date: _____

MEDICAL HISTORY:

Do you or your doctor have any concerns about your health? Yes No If yes, please describe:

Please check all that apply or have applied to you at any point in your life:

	You	Family		You	Family
Allergies			Heart Disease		
Anemia			High/ Low Blood Pressure		
Asthma			Pace Maker		
Headaches/ Migraines			Respiratory Illness other than Asthma		
Diabetes			Sleep Disorder / Apnea		
Dizziness			Gastrointestinal Problems		
Epilepsy/ Seizures			Substance Abuse		
Fainting			Thyroid Problems		
High Cholesterol			Cancer		
Stroke			Kidney Problems		
Nervous System Disorder			Blood Disorder		
Pain Disorder			Other (please be specific)		

HEAD INJURIES:

Have you ever had any history of head injury, sports injury to the head, falls, concussions, or car accidents?

Yes No

Was there any loss of consciousness or amnesia?

Yes No

Was there any change in mood, memory or behavior since the head trauma?

Yes No

Were you hospitalized for the head injury?

Yes No

Was any type of scan performed (CAT,MRI, SPECT, PET, EEG,etc)

Yes No

How severe was the head injury?

Mild Moderate Severe

Please describe where the head injury occurred, age of trauma, any treatment received, and/or test findings:

MEMORY & COGNITION:

Are you having trouble remembering things, concentrating, or attending to tasks? Yes No

Do you have difficulty slowing down your mind/resting?

Yes No

Please describe any remaining memory or cognitive issues you would like to address:

Name: _____ Date: _____

SLEEP HABITS:

On average, what time do you go to bed? _____ Wake Up? _____

On average, do you sleep continuously through the night without waking? Yes No

How is the quality of your sleep? Light Deep Other

Do you need a stimulant like coffee, coke, etc. to help you wake up? Yes No

NUTRITIONAL HABITS:

Nutritional habits (detailed description of one day's typical meals).

Breakfast _____

Lunch _____

Dinner _____

How often do you eat out? _____

SUBSTANCE USE:

	Yes	No	If yes, how much and how often per week?
Alcohol			
Nicotine			
Coffee/Tea			
Energy Drinks – ie. Red bull			
No Doze, Provigil, etc.			
Recreational Drugs- (Cocaine, Meth, ecstasy, Marijuana, etc)			
Other Substances			

Have you ever been diagnosed or treated for substance abuse in the past? Yes No

If yes, when and/or what type of treatment did you receive?
