



PLEASE PRINT ALL INFORMATION

Client Information

Today's Date: _____ Contact Number: _____ Male Female

Client Name: _____ DOB: _____ Age: _____

Address: _____
Number and Street City State Zip

Main Contact(s): *(If not the Client, other contacts)*

Name	Relationship	Cell Phone	Email Address

Messages: If we call you, may we leave a message with someone else? Yes No
 May we leave a voicemail message? Yes No
 Can we text or email appointment reminders? Yes No
 If yes, name of cell phone provider: _____

Appointment Reminders: Text Email Both None

Goals for training or primary problem(s) you'd like to improve: _____

Other providers helping with these issues _____

How did you hear about us? _____

List all prescribed medications:

Medication(s)	How long on them?	Comments	Medication(s)	How long on them?	Comments

List all supplements/OTC medications:

Supplement(s)/OTC	How long on them?	Comments	Supplement(s)/OTC	How long on them?	Comments

Center for Brain Training

550 Heritage Drive, Suite 140 | Jupiter, FL 33458 | www.CenterForBrain.com | (561) 744-7616

CLIENT NAME: _____ **DATE:** _____

What brings you here today?

- Anxiety
- Sleep
- Depression
- Processing or cognitive difficulties
- Attention issues
- Pain/headaches
- Other: _____

Handedness: Right Left Ambidextrous

Have you ever:

- had a concussion? been hit very hard in the head?
- lost consciousness? had a head injury

Explain: _____

Sleep Patterns:

Typical times you go to sleep: _____

Typical times you wake: _____

Sleep through the night? Yes No Sometimes

Fall asleep easily? Yes No Sometimes

How long to fall asleep? (minutes/hours) _____

Wake up easily? Yes No Sometimes

Wake feeling rested? Yes No Sometimes

Good sleep per week: 1-2 nights 3-4 nights 5-6 nights Almost always

Other comments about your sleep _____

	<u>Comments</u>
Are you sensitive to caffeine? <i>(Coffee, Tea, Chocolate, Cola)</i>	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does caffeine make you...	_____
<input type="checkbox"/> Alert/awake <input type="checkbox"/> Jittery/wired/hyper <input type="checkbox"/> Relaxed <input type="checkbox"/> No effect	
Do you use alcohol?	_____
<input type="checkbox"/> Never <input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Less	
Does alcohol make you...	_____
<input type="checkbox"/> Tired <input type="checkbox"/> Relaxed <input type="checkbox"/> Better <input type="checkbox"/> Worse	
Do you have a history of using recreational drugs?	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	

If yes, explain: _____

Do you have any psychiatric or mental health diagnosis? Yes No

If yes, any related hospitalizations?

Have you had any suicidal thoughts or thoughts of self-harm? Yes No

Plans? Yes No

Attempts? Yes No

If yes, explain: _____

Adult Name: _____

(Fill out what you can)

Any Important family history issues that may relate to current challenges/symptoms (divorce, disruptions in family, major job challenges, loss of family or friend, etc.)

History of help utilized:

- Counseling or Behavioral Therapy
- Exercise of Yoga
- Medications
- Acupuncture/massage
- Special diets or nutrition

Comments: _____

How long have you been dealing with your primary issues? _____

Are these issues that occur every day all day, or intermittently? How often do they occur? _____

Has anything helped these issues in the past? _____

Does it hinder your ability to engage in activities or work or be with family or friends? _____

PHYSICAL: Headaches Stomach issues Constipation Other _____

Can you describe physical symptoms – for example: hands sweating, chest tightening, tight stomach, hard to breathe, etc. _____

Any history of trauma/being bullied/abuse: _____

Do you think you have problems keeping up/being sharp/making decisions? _____

Healthy self-esteem?

Excessively obsessive or worried?

Easily overwhelmed?

How would you describe yourself? _____

Is there excessive sensitivity to light/sound/noise? _____

This is a "Gut-Brain question": Estimate how many rounds of antibiotics you've had since you were born: _____
