CENTER FOR BRAIN
A HIGH-TECH GYM FOR THE BRAIN

PLEASE PRINT ALL INFORMATION

Client Information

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

Client Name: _____ **DOB:** _____ **Age:** _____

Address: _____ **Email:** _____
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
A HIGH-TECH GYM FOR THE BRAIN

Client Information

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	_____			

					Comments
Are you sensitive to caffeine? *(Coffee, Tea, Chocolate, Cola)*	☐ Yes	☐ No			
Does caffeine make you…	☐ Alert/awake	☐ Jittery/ wired/hyper	☐ Relaxed	☐ No effect	
Do you use alcohol?	☐ Never	☐ Daily	☐ Monthly	☐ Less	
Does alcohol make you…	☐ Tired	☐ Relaxed	☐ Better	☐ Worse	
Do you have a history of using recreational drugs?			☐ Yes	☐ 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 History

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 or 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: _____