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

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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: _____

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Child History

Child Name: _____ ***(Fill out what you can)***

Any Important family history issues related to child (divorce, disruptions in family, loss of family, adoption, foster, etc.)

_____

_____

History of help utilized:

- ☐ Counseling or Behavioral Therapy — Comments: _____
- ☐ Occupational Therapy _____
- ☐ Tutoring _____
- ☐ Speech _____
- ☐ Medications _____
- ☐ Special diets or nutrition _____

Any IEP or 504 plan or accommodations? _____

Greatest Strengths: _____

Any developmental or other early relevant history: _____

_____

PHYSICAL: ☐ Headaches ☐ Stomach issues ☐ Constipation ☐ Other _____

Does the child GET ALONG well with…?					Comments:
	Parents/Step-Parent/Guardian	☐ Yes	☐ No	☐ Sometimes	
	Siblings	☐ Yes	☐ No	☐ Sometimes	
	Friends and Peers	☐ Yes	☐ No	☐ Sometimes	
	Teachers	☐ Yes	☐ No	☐ Sometimes	

ACADEMICS: Is the child doing well academically? ☐ Yes ☐ No

Is the child behind grade level in ☐ Reading ☐ Math ☐ Spelling ☐ Other Subjects

Are there other subjects the child struggles more with than others? _____

_____

Does your child avoid activities? ☐ Yes ☐ No If so, why? _____

Is there difficulty shifting from one activity to another (transitioning)? ☐ Yes ☐ No

How would you describe this child? _____

_____

Is there healthy self-esteem? ☐ Yes ☐ No Is the child fearful? ☐ Yes ☐ No

Is there excessive sensitivity to light/sound/noise? ☐ Yes ☐ No