CENTER FOR BRAIN

Adult Client Information

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

First Name: _____ **Last Name:** _____ **DOB:** _____ **Age:** _____

Address: _____ **Email:** _____
Number and Street City State Zip

Main Contact(s): *(If not the client, list other contacts' name, relationship, cell phone and 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
May we send appointment reminders: ☐ Text ☐ Email ☐ Both ☐ None

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

Other providers helping with these issues *(please provide contact details)*

How did you hear about us?
☐ *Medical professional ☐ *Mental Health professional
☐ Friend or acquaintance ☐ Facebook ☐ Internet search ☐ Article or ad
☐ Psychology Today ☐ Center for Brain Training website ☐ Informational Seminar

***If medical or mental health professional, please provide name, city, state*

List all prescribed medications, how long you have been on them and any comments:

List all supplements/OTC medications, how long you have been on them and any comments:

Adult Client Information

First Name: _____ **Last Name:** _____ **Date:** _____

What brings you here today? ☐ Depression ☐ Anxiety ☐ Sleep ☐ Attention issues ☐ Pain/headaches
☐ Processing or cognitive difficulties ☐ _____

Handedness: ☐ Right ☐ Left ☐ Ambidextrous

Which of these have you experienced? ☐ Concussion or head injury ☐ Very hard hit on the head
☐ Lost of consciousness ☐ Whiplash ☐ None

Explain:

Sleep Patterns:

What time do you typically fall asleep _____

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

Wake up easily?	☐ Yes	☐ No	☐ Sometimes	☐ Never or almost never
Typically sleep through the night, except for getting up to go to the bathroom?	☐ Yes	☐ No	☐ Sometimes	☐ Never or almost never
Wake feeling rested?	☐ Yes	☐ No	☐ Sometimes	☐ Never or almost never

Comments about your sleep:

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 ☐ Occasionally/Socially

Does alcohol make you… ☐ Tired ☐ Relaxed ☐ Better ☐ Worse ☐ N/A

Do you have a history of using recreational drugs? ☐ Yes ☐ No

If yes, explain:

Do you have any psychiatric or mental health diagnoses? ☐ Yes ☐ No

If yes, explain:

Have you had any hospitalizations related to a psychiatric or mental health issue? ☐ Yes ☐ No

If yes, explain:

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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Adult History

First Name: _____ **Last Name:** _____ ***(Fill out what you can)***

Provide 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 ☐ Exercise or yoga ☐ Medications ☐ Acupuncture/massage ☐ Special diets or nutrition	Comments:

How long have you been dealing with your primary issues?

How often do these issues occur? ☐ Every day ☐ Many days each week ☐ Occasionally

What, if anything has helped these issues in the past?

How much do your issues hinder your ability to engage in activities or work or be with family or friends?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

Which, if any, of the following physical symptoms do you sometimes experience? *(Check all that apply)*

☐ Sweating hands ☐ Tight chest ☐ Tight stomach ☐ Difficulty breathing

Other *(please explain)*

Do you have any history of trauma/being bullied/being physically or emotionally abused? ☐ Yes ☐ No

If yes, please explain:

Do you sometimes have problems keeping up/being sharp/making decisions? ☐ Yes ☐ No

If yes, please explain:

Check any of these which apply: ☐ Poor self-esteem ☐ Excessively obsessive or worried ☐ Easily overwhelmed

How would you describe yourself?

Do you have excessive sensitivity to light/sound/noise? ☐ Yes ☐ No

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