Family Holistic Health Care of Fairfield
Neurobiofeedback Services

Laura R. Koch OT • 1100 Kings Highway East • Fairfield, CT 06825 Suite 1C • 203 576-1993

Neurointegration Intake Form

Name: ______________________________
D.O.B.: ___/___/___ Gender: □Male □Female
Street Address: ______________________________
Town, State, Zip Code: ______________________________
Home Phone: ______________ Cell Phone: ______________
Email Address: ______________________________
Occupation: ______________________________
Referred by: ______________________________
Emergency Contact Name: ______________________________
Relationship: ______________ Phone #: ______________
Diagnosis/Reason for Referral: ______________________________
What symptoms would you like addressed through Neurointegration Training? ______________________________

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Please answer the following questions to the best of your ability.

1. **Overall Health**

   On a scale of 1-10, how would you rate your current health? 1 2 3 4 5 6 7 8 9 10
   (1 being the worst, 5 being average, 10 being the best)

2. **Sleep**

   Rate the quality of sleep you usually get in the past month. 1 2 3 4 5 6 7 8 9 10
   At what time do you usually go to bed? ________am/pm
   At what time do you usually rise for the day? ________am/pm
   Are you able to sleep through the night? Yes No
   If NO, please describe: ______________________________

   ____

   Are you able to fall asleep easily most nights? Yes No
   If NO, please describe: ______________________________

   ____

   Do you wake refreshed? Yes No
   If YES, please describe any exceptions: ______________________________

   ____

3. **Head or Neck Injury**

   Have you ever injured your head or neck? Yes No
   Have you ever had a concussion? Yes No
   If YES, have you suffered from more than one concussion? Yes No
   Have you ever been in a car, motorcycle, or bike accident? Yes No
   Have you ever had a traumatic brain injury? Yes No
   Are you currently receiving care for this/these injuries? Yes No
   Please describe your head or neck injury(ies). Consider childhood, teen, and adulthood (if applicable), including home life, sports, accidents, slips/falls, etc. (use back if necessary): ______________________________

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4. Attention and Learning

Do you have a history of learning difficulties?	Yes	No	
Do you have a history of ADD/ADHD?	Yes	No	
Do you have a history of memory problems?	Yes	No	

5. Moods & Emotions

Do you feel depressed or anxious in general?	Yes	No	
Have you suffered from depression or anxiety in the past?	Yes	No	
Have you been diagnosed with Obsessive Compulsive Disorder (OCD)?	Yes	No	
Have you ever experienced panic attacks?	Yes	No	
Do you have any history of psychiatric conditions in yourself such as schizophrenia, bi-polar disorder, or psychosis?	Yes	No	
Is there a family history of psychiatric conditions such as schizophrenia, bi-polar disorder, or psychosis?	Yes	No	
Have you ever contemplated suicide?	Yes	No	

How would you describe your general emotional state? (A brief sentence or short phrase is fine.)

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6. Substances

Do you <u>currently</u> use psychoactive drugs, medications, or alcohol to pick yourself up or calm yourself down?	Yes	No	
Have you ever used psychoactive drugs, medications, or alcohol <u>in the past</u> to pick yourself up or calm yourself down?	Yes	No	
Are you currently a smoker?	Yes	No	
Do you consider your current use of tobacco, alcohol, or street drugs a problem?	Yes	No	N/A

7. Hormones

Are you concerned that hormonal imbalances may be contributing to your condition?	Yes	No	

8. Counseling & Psychotherapy

Are you currently working with a psychiatrist, social worker, therapist, counselor, or clergy in matters regarding your mental health?	Yes	No	

9. Medications, Supplements & Vitamins (use back if necessary)

Name	Dosage/Frequency	Symptom

10. Allergies

List any medication, food, and/or environmental allergies. ______________________________

____

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11. Light Sensitivity

Are you or have you ever had sensitivity to lights or strobe lights? Yes No

12. Other Health Issues

- ☐ Autism
- ☐ Chronic Fatigue
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Headache/Migraine
- ☐ High Blood Pressure
- ☐ Parkinson's
- ☐ Other (Please describe)
- ☐ PMS
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Teeth Grinding
- ☐ Thyroid Problem
- ☐ Tinnitus (Ringing in Ears)
- ☐ TMJ

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FAMILY HOLISTIC HEALTH CARE AND NEUROBIOFEEDBACK SERVICES
1100 Kings Highway East Suite 1C
Fairfield, CT 06825

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent (see binder on Waiting Room book rack). The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also for the practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following: that appointment reminders will be used by the Practice. A separate form will be used to allow me to choose email and/or text notifications. I have the option to deny either or both.
4. The Practice may use/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary, for the Practice to conduct its specific health care operations.
5. I understand that the Practice may want to use my PHI to communicate with the CCA (Connecticut Chiropractic Association) to receive their assistance if necessary to resolve a dispute with an insurance company when a claim is denied or reduced. It has been explained to me that I can restrict the use of my PHI now or at a later date for the above expressed purposes.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to what the Practice has already taken action on in reliance on this consent.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________________ ______________________________

Name of Individual (Printed) Signature of Individual

Date Signed _____/_____/_____

*If patient is a minor or unable to consent, parent/guardian/health proxy should complete below.

______________________________ ______________________________

Signature of Legal Representative Relationship

Family Holistic Health Care

1100 Kings Highway East

Fairfield, CT 06825

203 576-1993

In order that we can send you statements, visit summaries (if requested), and other correspondences such as visit reminders, please provide us with your email address and cell phone information.

Email Address: ____

Cell Phone Number: ____

Cell Phone Carrier: ATT __________ Verizon __________

Sprint __________ T Mobile __________

Cingular __________ Boost __________

Metro __________ US Cell __________

Virgin __________

I would like to receive appointment reminders via:

Email _______

Text ________

Email and Text _______

Print Name: ______________________________

Signature: ______________________________

Date: ________________