Neurotherapy Center of Houston
A BRAIN FITNESS CLINIC

Intake Record

Name:_____ Date:_____ Gender:_____

Date of Birth: _____ Email:_____

Address:_____ City:_____ Zip: _____

Marital Status _____ How did you hear about us? _____

☐ Home:_____ ☐ Work:_____ ☐ Cell:_____

Please check if it is OK to leave a message

1. What are the presenting symptoms/problems to be addressed by neurofeedback?
Please indicate severity on a scale of 1-10 (10 = most severe).

2. When did these symptoms/problems first become noticeable?

3. What have been the major consequences of these symptoms/problems?

4. What else have you tried to address these symptoms/problems?

5. Is there a family history of these symptoms/problems?
(please be specific as to family relationship)

6. Medical/Psychological History
Please indicate and briefly explain your experience with any of the following.

Birth trauma/Issues

High fevers/chronic ear infections or ear tubes

Current medical conditions

Current prescription medications and dosages

Over the counter medications (include vitamins and herbal remedies)

Sleep issues (trouble falling asleep, staying asleep)

Head injuries (car accidents, sports, etc.)

Current or past memory difficulties

Chemical exposure (lead-based paints, refineries, etc.)

Substance use (currently and in the past, including illicit substances, tobacco, and alcohol)

History of psychological diagnoses and treatment

History of physical/emotional/verbal/sexual abuse

History of previous suicide attempts

History of unusual states of consciousness (hallucinations, loss of time, out of body, etc.)

7. Treatment Goals (What would you like the outcome of training to be?)