

Marin Biofeedback
INTAKE / HISTORY

Name: _____ Age: _____ DOB: _____

Address: _____

City/State/Zip: _____

Phone: (home) _____ (____) _____ email: _____

Handedness R L

Parent(s) or Guardian(s) of minor: _____ **Insurance:** _____

Name(s): _____

Address: (if different from above) _____

City/State/Zip: _____

Phone: (home) _____ (____) _____ (____) _____

Referral source if referred to this office: _____ **Phone:** _____

Physician / other health care professional (chiropractor, therapist, naturopath, bodyworker, etc):

Name: _____ Phone: _____

Diagnosis: _____

Current medications: _____

Rx: _____ Dose: _____ When Taken: _____ How Long: _____

Rx: _____ Dose: _____ When Taken: _____ How Long: _____

Rx: _____ Dose: _____ When Taken: _____ How Long: _____

Briefly list other approaches you have tried for this condition: (Medication, behavior therapy, counseling, alternative medicine, etc.?)

What benefits do you hope to gain from biofeedback and/or neurofeedback? _____

Developmental History – Please indicate your (or your child’s) history in relation to the following:

| <u>Prenatal and Birth</u> | <u>Yes</u> | <u>No</u> | <u>Details</u> |
|--------------------------------------|-------------------|------------------|-----------------------|
| Prenatal stress or injury | _____ | _____ | _____ |
| Prenatal drug/alcohol exposure | _____ | _____ | _____ |
| Birth trauma (forceps, breech, etc.) | _____ | _____ | _____ |
| Anesthesia, pain medications | _____ | _____ | _____ |
| Anoxia (oxygen deprivation @ birth) | _____ | _____ | _____ |
| Premature/late delivery | _____ | _____ | _____ |

| | | | | |
|---|-----------------------|--------------------|-----------------------|-----------------------|
| Medical problems after birth | _____ | _____ | _____ | _____ |
| Birth weight _____ | | | | |
| Adopted at age _____ | | | | |
| Other _____ | | | | |
| <u>Growth and Development</u> | <u>Typical</u> | <u>More</u> | <u>Less</u> | <u>Details</u> |
| Activity level | _____ | _____ | _____ | _____ |
| Motor/coordination development | _____ | _____ | _____ | _____ |
| Infections/allergies | _____ | _____ | _____ | _____ |
| Emotional development | _____ | _____ | _____ | _____ |
| Behavior concerns | _____ | _____ | _____ | _____ |
| Handedness development | _____ | _____ | _____ | _____ |
| Appetite/digestion | _____ | _____ | _____ | _____ |
| Language/speech development | _____ | _____ | _____ | _____ |
| <u>Physical Traumas</u> | <u>Yes</u> | <u>No</u> | <u>Details</u> | |
| Head injury (even minor falls, etc.) | _____ | _____ | _____ | |
| Coma (loss of consciousness) | _____ | _____ | _____ | |
| Accidents (list all) | _____ | _____ | _____ | |
| High fever | _____ | _____ | _____ | |
| Serious illness | _____ | _____ | _____ | |
| Surgery | _____ | _____ | _____ | |
| CNS infection | _____ | _____ | _____ | |
| Drug overdose/poisoning | _____ | _____ | _____ | |
| Recreational drug use | _____ | _____ | _____ | |
| Anoxia | _____ | _____ | _____ | |
| Stroke | _____ | _____ | _____ | |
| <u>Psychological Stress/Life Changes</u> | <u>Yes</u> | <u>No</u> | <u>Details</u> | |
| Death in family | _____ | _____ | _____ | |
| Divorce/remarriage | _____ | _____ | _____ | |
| Move/relocation | _____ | _____ | _____ | |
| School change | _____ | _____ | _____ | |
| Job change | _____ | _____ | _____ | |
| Family member chronic illness | _____ | _____ | _____ | |

Symptom Checklist

Please indicate if the **client** and/or **family member(s)** (parents, grandparents, brothers, sisters, aunts, uncles, and/or children) **currently experience (C)** or have a **history (H)** of any of the following symptoms.

| <u>Symptom</u> | <u>if client</u> | <u>if family</u> | <u>Symptom</u> | <u>if client</u> | <u>if family</u> |
|----------------------------|------------------|------------------|----------------------------|------------------|------------------|
| <u>Feeling Tense</u> | _____ | _____ | <u>Feeling lonely</u> | _____ | _____ |
| <u>Depressed</u> | _____ | _____ | <u>Frequent illness</u> | _____ | _____ |
| <u>Always on the go</u> | _____ | _____ | <u>Repetitive thoughts</u> | _____ | _____ |
| <u>School/work problem</u> | _____ | _____ | <u>Repetitive behavior</u> | _____ | _____ |
| <u>Impulsivity</u> | _____ | _____ | <u>Shy with People</u> | _____ | _____ |
| <u>Hyperactivity</u> | _____ | _____ | <u>Allergies</u> | _____ | _____ |
| <u>Attention problems</u> | _____ | _____ | <u>Asthma</u> | _____ | _____ |
| <u>Behavior problems</u> | _____ | _____ | <u>Seizures</u> | _____ | _____ |
| <u>Vocal or motor tics</u> | _____ | _____ | <u>Chronic pain</u> | _____ | _____ |
| <u>Sleep problems</u> | _____ | _____ | <u>Food sensitivity</u> | _____ | _____ |
| <u>Legal trouble</u> | _____ | _____ | <u>Head injury</u> | _____ | _____ |
| <u>Headaches</u> | _____ | _____ | <u>Memory problems</u> | _____ | _____ |

Temper tantrums _____
Rages _____
Verbal Aggression _____
Physical Aggression _____
Stubbornness _____
Addictions _____
Bowel disturbances _____
Chronic fatigue/FMS _____
Inferiority feelings _____
Dizziness _____
Fainting spells _____
Heart palpitation _____
Stomach trouble _____
Poor appetite _____
Picky eater _____
Nightmares _____
Alcohol/drug problem _____

Feeling panicky _____
Tremors _____
Suicidal ideas _____
PMS _____
Physical/sexual abuse _____
Over ambitious _____
Unable to relax _____
Can't make decisions _____
Communication prob. _____
Problems at home _____
Financial problems _____
Any chronic illness _____

Other, specify: _____

Please circle the **five current problems** listed above which are the **most distressing** to you or your child.

Therapist's comments: _____

_____ **Date:** _____