PLEASE COMPLETE THE ATTACHED

INTAKE CONSULTATION FORM

____

NAME

____

APPOINTMENT DATE AND TIME

NOTICE

Please be aware that insurance companies and other agencies may request copies of this intake form, as well as written session notes from our office, in order for your insurance benefits to be paid. If you **do not** wish this information to be released please inform the office staff. You will be asked to sign a release form prior to your initial visit.

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Date: ___________________

Interviewer: __________________

Referred By: _________________

Allergies, i.e., medications: ____

1. Name: _____________________________ **Male / Female** Birth Date ___ / ___ / ___

2. Home Address ______________________________ City _____________________ State ____ Zip ______

   Phone (Home) ________________ (Office) _____________ (Cell) ___________ (Email) ____________

3. Employer _____________________________ Occupation ____

4. Employer Address ___________________________ City _____________________ State ____ Zip ______

5. Marital Status _______ Years Married ______ Height ______ Weight ______Right / Left Handed

6. Spouse's Name ____________________________ Birth Date ____ / ____ / _____ SS# ____ - ____ - ____

7. Spouse's Employer/Address ____ Phone__________

8. Parents **(Father)** _________________________ **(Age)** ____ **(Mother)** __________________________ **(Age)** ___

9. Children __________ Sex (M) ____ (F) ____ Location ____

10. Brothers ____ Sisters ____ Location ____

11. Person to contact in emergency __________________________________ Relationship _______________

    Telephone # (   ) _______________ Address ____

12. Hobbies ____

    (***How do you spend your free time?)***

13. Physical exercise ____

    (Amount/type & frequency)

NAME ______________________________ DATE ______________

Do you have any of these common symptoms? Please note their intensity and frequency. Please include all symptoms, even if you consider them unimportant.

Range: From none **(0)** to overwhelming **(10)** – **(e.g., 3 – 7)**
Frequency: Times a Day **(D)**, Week **(W)**, Month **(M)**, or Year **(Y)** – **(e.g., 3 x D)**

PHYSICAL SYMPTOMS **Circle Symptom**	**RANGE OF INTENSITY**	**FREQUENCY OF OCCURRENCE**
1. Cold hands or feet		
2. Hot or cold spells		
3. Headaches		
4. Neck, shoulder, back or other muscle pain		
5. Pains or tightness in chest or heart		
6. Frequent illness		
7. Sweating hands, feet, etc.		
8. High or low blood pressure		
9. Nausea, vomiting, upset stomach		
10. Diarrhea, constipation		
11 Stomach aches, abdominal pains		
12. Heart pounding, racing, arrhythmias		
13. Muscle twitches or tremors		
14. Nervousness, shakiness, trembling, tremors		
15. Coronary heart disease		
16. Easily fatigued, low energy, burnout		
17. Premenstrual syndrome (PMS)		
18. Pain or sensitivity to light or noise		
19. Dizziness or vertigo or faintness		
20. Coordination problems		
21. Itching, skin disorders		
22. Dry throat or mouth		
23. Teeth grinding or clenching		
24. Frequent urination		
25. Accident, injury prone		
26. Trouble getting your breath		
27. Body numbness or tingling		
28. A lump in your throat		
29. Weakness or heaviness of body		
30. Eating disorders, loss or increase of appetite		
31. Loss or excessive interest in sex		
32. Other pain		

NAME ____________________ DATE ____________

BEHAVIORAL/EXPERIENTIAL SYMPTOMS Circle Symptom		RANGE OF INTENSITY	FREQUENCY OF OCCURRENCE
33.	Nail biting		
34.	Having trouble falling or staying asleep		
35.	Unable to get rid of negative thoughts/ideas		
36.	Unusual body feelings		
37.	Anxiety, fear, apprehension, panic		
38.	Feeling critical of others		
39.	Nightmares		
40.	Stuttering, stammering, etc.		
41.	Trouble remembering things, mind goes blank		
42.	Worried about sloppiness		
43.	Feeling easily annoyed, angered, irritated		
44.	Feeling confused		
45.	Crying easily		
46.	Temper outbursts you cannot control		
47.	Blaming yourself for things		
48.	Impulsive behavior, emotional instability		
49.	Fidgety, restless, antsy, impatient		
50.	Feeling blocked in finishing tasks		
51.	Feeling lonely, separate, sad		
52.	Substance abuse – food, alcohol, drugs		
53.	Worry, concern, feeling serious		
54.	Feeling no interest in things		
55.	Feeling guilty, shame		
56.	Feelings being easily hurt		
57.	Feeling others are not sympathetic		
58.	Doing things slowly to be sure they are right		
59.	Feeling inferior to others		
60.	Having to double check what you do		
61.	Difficulty making decisions		
62.	Wanting to be alone		
63.	Trouble concentrating, distracted		
64.	Mood swings		
65.	Feeling hopeless about the future		
66.	Feelings of unreality / unusual mental events		
67.	Depression, withdrawal, procrastination, resistance		
68.	Feeling self-conscious		
69.	Talking too much		
70.	Feeling you are watched or talked about by others		
71.	Feeling people are unfriendly or dislike you		
72.	Feeling others are to blame for your troubles		
73.	Feeling people will take advantage if you let them		
74.	Feeling something is wrong with your mind		
75.	Lack of motivation, interest		
76.	Reduction in accuracy, productivity		
77.	Sexual shyness – disorders		

If you exhibit more than a few of these symptoms, you are experiencing the effects of stress and would benefit from learning to reduce stress and pain.

NAME ____________________ DATE ____________

MEDICAL/PSYCHOLOGICAL

1. Primary symptom (s) complaint (s) for which treatment is desired.
   1. ____________________
   2. ____________________
   3. ____________________
   4. ____________________

2. Date and conditions surrounding first appearance of each symptom.
   1. ____________________
   2. ____________________
   3. ____________________
   4. ____________________

3. Who diagnosed symptoms? (Name & Address) ____________________

   What was diagnosis? ____________________ When was it diagnosed? __________

4. Past/current medical or psychological problems related to primary symptoms: ____________________

5. Last thorough physical examination by a physician. ____________________
   Name of physician ____________________Date ____________
   Outcome and recommendations ____________________

6. Dates and outcome of previous medical/neurological workups or interventions (pain/other injections, hospitalizations, surgery, physical or other therapy, brain scan, skull x-ray, clinical EEG or other).

Dates	Kind of Exam or Treatment	Outcome

7. Family physician and other physicians currently treating you (Names, addresses)
   Family Physician ____________ Address ____________________
   Other Treating Physician ____________ Address ____________________

   Physician to whom you wish a report sent ____________________
   (Name and Address)

8. Previous/current psychological/psychiatric experience

Psychologist/Psychiatrist	Dates of Treatment or Exam	Diagnosis

Have you ever been hospitalized for psychological reasons? ____________ When ____________

NAME ____ DATE _______________

9. Current medications (Please list all prescribed medications currently used)

Symptom Being Treated	Name of Medication	Dosage	Frequency of Use	Effectiveness (0 – 10)	Side Effects (0 – 10)	Prescribing Physician	Starting Date

10. Relevant medications used in the past and symptoms being treated.

____

____

11. Use of non-prescription medication (e.g., aspirin, Tylenol, decongestants, sleep medications, nasal sprays, inhalers, vitamins, other supplements).

____

____

12. Past/current use of stimulants and social drugs (please check and describe frequency).

Alcohol ______ Cigarettes ______ Marijuana _______ Coffee _______ Tea _______ No Doz _______
Other Substances ____

13. Nutritional habits (detailed description of 1 day's typical meals).
Breakfast ____
Mid-Morning Snack ____
Lunch ____
Mid-Afternoon Snack ____
Dinner ____
Evening Snack ____

Use of stress foods – please circle and describe frequency.

Sugar Candy Desserts Soft Drinks Salt Chocolate

How often do you eat out? ____

14. General health (Prenatal & perinatal events with developmental history). Please use reverse side if more space is needed.
Childhood ____
____
Adult ____
____

NAME ______________________________ DATE ______________

15. **Medical History: Check Symptoms and Disorders**

Type	Self	Description or Frequency of Occurrence	Other Family Members
Headaches			
Arthritis			
Allergies			
Asthma			
Alcoholism			
Diabetes			
Epilepsy			
High Blood Pressure			
Heart Disease			
G.I./G.U. Disorders			
Cancer			
Emotional Problems			
Insomnia			
Other Symptoms			
Other Disorders			

Describe any occasions when you have lost consciousness or fainted ______________________________

____

16. What are your expectations or reactions concerning your symptoms (e.g., **optimistic, anxious, guilt, frustrated, angry, hopeless, self-doubt, self-pity, fatalistic, withdrawn,** etc.?)

____

____

Responses of significant others to symptoms (**spouse, family, friends, employer,** etc.) ______________

____

GENERAL/PSYCHOLOGICAL

17. Please briefly describe characteristics or personality styles of each (5-10 words):

Spouse/boy friend/girl friend ______________________________

____

Self ______________________________

Children 1. ______________________________

2. ______________________________

3. ______________________________

Marital and/or family relationships. What are the major stresses in your family life?

____

Father ______________________________

Mother ______________________________

Do you like your job? School? ______________________________

What are the major stresses in your job? School? ______________________________

How would you describe your relationships with others (friends, employers, employees)? ______________

Friends ______________________________

Employers/Employees ______________________________

NAME ____ DATE ________________

What words would you use to describe your typical daily mood?
Morning ____
Day ____
Evening ____

18. How well can you relax when you have no special problems? (**Rate from 0-10**) ___________________
    How well can you relax when you need to relax? (**Rate from 0-10**) ______________________________
19. Do you do anything specifically to relax, i.e., have you any knowledge and/or experience with any of the systematic relaxation techniques, such as meditation, yoga, autogenic training, biofeedback training etc.?
    ____
    What do you do on a daily basis specifically to relax? When do you do this and how much time do you spend? ____

20. Typical daily schedule (please put in approximate times and describe activities during leisure hours).

Time arising ______________	Spouse home from work ___________
Dress, etc. ________________	Dinner _______________________
Breakfast _________________	Evening activities ________________
Work schedule _____________	_____________________________
Lunch ____________________	Go to bed _____________________
Home from work ___________	Go to sleep ____________________

How many hours per day do you watch television? ________________________________

TO BE FILLED OUT BY THERAPIST

MEDICAL/PSYCHOLOGICAL

1. What emotional feeling is dominant when the symptom is present or most intense? (e.g., **nervousness, worry, fear, anger, frustration,** other)____

2. Do you have any warning that the symptom is coming on or will increase in intensity (e.g., **feeling nervous, depressed, muscle tension, or other mental or emotional state**) ______________________

3. What reduces or alleviates each symptom? (e.g., **activity, medication, food, beverages, relaxation, sleep,** etc.) ____

4. What increases the severity of each symptom? (e.g., **foods, stressful situation, activity, medication**)
   ____

5. Have you noticed any time patterns in relation to the occurrence of your symptoms? (e.g., **time of day/ week/month, sleeping vs. waking, menstrual cycle, seasonal change, weather,** etc.) _____________
   ____

6. Have you noticed that certain feelings or situations might be associated with the onset of symptoms? (e.g., stressful events, impending social/familial/occupational engagements, etc.) ____________________
   ____

NAME ______________________________ DATE ______________

7. How are daily activities limited before/during/following the appearance of each symptom? ______________________________

8. How would your life be different without your symptom (s)? ______________________________

9. What, if any, benefits do you receive from your symptoms (e.g., attention from others, opportunity to take it easy, distraction from personal problems) ______________________________

10. Detailed description of symptom (s) / complaint (s) for which biofeedback training is desired. For each symptom:

SYMPTOM	LOCATION	QUALITY OF PAIN	INTENSITY (0 - 10)	DURATION	FREQUENCY OF OCCURRENCE

11. Do you experience suicidal thoughts? ______________________________
Have you ever attempted suicide? ______________________________
Do you think you might ever attempt suicide? ______________________________