INTAKE QUESTIONNAIRE Date___ _____

PLEASE FILL OUT THIS APPLICATION IN DETAIL

PATIENT INFORMATION

Patient Name	Age	DOB
Address		
City/State/Zip		
Phone (home)	Cell	
Email Address		

PARENT(S) OR GUARDIAN(S) OF MINOR

Patient Name	Age	DOB
Address		
City/State/Zip		
Phone (home)	Cell	
Email Address		

PLEASE DESCRIBE YOUR COMPLAINTS (WHY YOU ARE HERE?)

PATIENT NAME _____ DATE_____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

	ADD		Seizure Disorders such as Epilepsy		Alzheimer's
	ADHD		Depression		Cognitive Impairment
	Traumatic Brain Injury		Bipolar Disorder		Stroke or Transient Ischemia
	Anxiety		Tourette's		High Blood Pressure
	Sleep Disorder		Migraines		Post Traumatic Stress Disorder
	Irritable Bowel		Allergies		Asthma
	Heart Attack		Heart Disease		Chronic Pain
	Fibromyalgia		Reflex Sympathetic Dystrophy (RSD)		Obsessive Compulsive Disorder
Please indicate any other pertinent diagnosis that is not listed above:					

WHO DIAGNOSED YOUR CONDITION(S) AND WHAT IS THEIR PROFESSION?

NAME	PROFESSION	CONDITION DIAGNOSED

PLEASE LIST ALL MEDICATIONS, WHO PRESCRIBED AND FOR WHAT CONDITION

MEDICATION	DOCTOR THAT PRESCRIBED	CONDITION TAKEN FOR

PATIENT NAME _____ DATE_____

SLEEP SYMPTOMS

	Difficulty going to bed		Restless legs
	Difficulty going to sleep		Bed wetting or soiling
	Wake up frequently		Nightmares
	Early awakening		Sleep too much
	Restless sleep		Sleep apnea
	Talking in sleep		Bruxism (teeth grinding)
	Walking in sleep		Vivid dreams
	Night Terrors		Night sweats

COGNITIVE SYMPTOMS

	Dyslexia		Poor visual spatial skills
	Poor word fluency		Poor sense of self in space
	Poor ability to process		Inability to write neatly
	Poor ability to plan		Poor fine motor skills
	Poor reading comprehension		Poor spelling
	Difficulty understanding words		Poor sense of direction
	Poor arithmetic calculation		Poor tracking during reading
	Indecisive		Poor memory

PAIN SYMPTOMS

	Chronic pain with depression		Chronic throbbing pain
	Chronic aching pain		Chronic stabbing pain
	Tension Headache		Chronic shooting pain
	Low pain tolerance		Sciatica pain
	Fibromyalgia		High pain tolerance
	Migraine		Peripheral neuropathy pain
	Jaw tension		Emotional reactivity to pain
	Chronic burning pain		Pain in the shoulders and neck

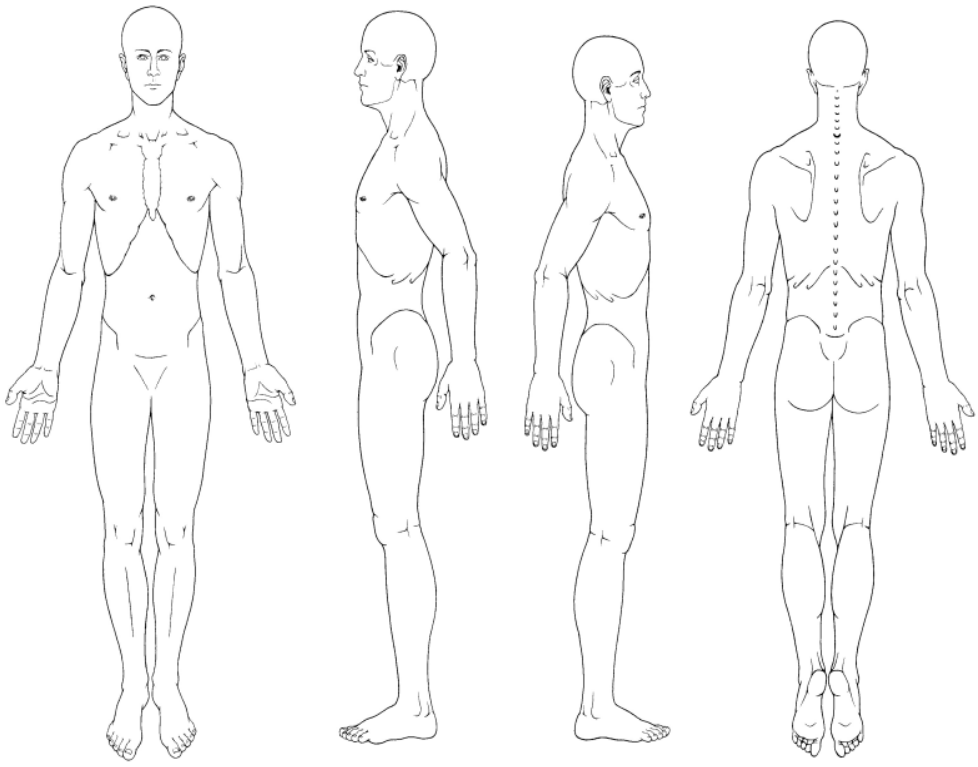
PATIENT NAME _____ DATE_____

IF YOU ARE EXPERIENCING PAIN, NUMBNESS, TINGLING, AND/OR BURNING SENSATIONS, THEN

PLEASE COMPLETE THE DIAGRAM BELOW

Please mark off the areas of your complaint on the diagram above with the following indicators:

PPP = pain
NNN = numbness
TTT= tingling
BBB= burning
CCC= cramping



PLEASE LIST FIVE GOALS THAT YOU HOPE TO ACHIEVE WITH BRAINCORE THERAPY

PATIENT NAME _____ DATE_____