NEW PATIENT PROFILE *Today's Date* _____

Please complete these pages as accurately as possible and completely as possible. If you need help, please ask. If possible please use a ***blue ink pen*** to make your form easier to read.

Name:_____ _____ _____ **Gender:** Male Female
FIRST MIDDLE LAST

Date of birth: ___ / ___ / _____ Current Age: _____ Height: _____ Weight_____

Home Street Address: _____ City_____

State:_____ Zip Code: _____ OK to mail correspondence to this address? Yes No

Home Phone: (_____) _____ OK to leave message? Yes No

Work Phone: (_____)_____ OK to leave message? Yes No

Mobile Phone: (_____)_____ OK to leave message? Yes No

E-mail: _____ _____ OK to leave message? Yes No

Occupation:_____ ____ Employer: _____

Emergency Contact: _____ Phone: (_____) _____

HEALTH INFORMATION — confidential

PRESENT HEALTH CONCERNS: Please list your most important health concerns. If possible, please list them in order of importance to you. For example, #1 is most important and #5 is least important.

1)_____ _____ _____

2)_____ _____ _____

3)_____ _____ _____

4)_____ _____ _____

5)_____ _____ _____

YOUR MAJOR GOALS FOR THERAPY: Please tell me what you would like to accomplish through neurotherapy?

1)_____ _____ _____

2)_____ _____ _____

3)_____ _____ _____

4)_____ _____ _____

5)_____ _____ _____

CURRENT MEDICATIONS AND DOSAGE _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ANY QUESTIONS ABOUT TODAY'S APPOINTMENT?

_____

_____

CONTACT INFORMATION

Primary Care Physician: _____ _____ _____
FIRST MIDDLE INITIAL LAST

Business Address: _____ _____

City:_____ State: _____ Zip Code: _____

Business Phone: (_____) _____ _____

FAX Number: (_____) _____ _____

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Former Psychologist: _____ _____ _____ _____
FIRST MIDDLE INITIAL LAST

Business Address: _____ _____

City:_____ State: _____ Zip Code: _____

Business Phone: (_____) _____ _____

FAX Number: (_____) _____ _____

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Psychiatrist: _____ _____ _____ _____
FIRST MIDDLE INITIAL LAST

Business Address: _____ _____

City:_____ State: _____ Zip Code: _____

Business Phone: (_____) _____ _____

FAX Number: (_____) _____ _____

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Former Counselor: _____ _____ _____ _____
FIRST MIDDLE INITIAL LAST

Business Address: _____ _____

City:_____ State: _____ Zip Code: _____

Business Phone: (_____) _____ _____

FAX Number: (_____) _____ _____

MEDICAL HISTORY

Check all that you now have or have had in the past (list any significant illnesses not listed):

- ❑ AIDS/HIV
- ❑ Acne treatment
- ❑ Alcohol dependence
- ❑ Allergies
- ❑ Alopecia/Hair loss
- ❑ Anemia
- ❑ Anxiety (persistent)
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma
- ❑ Attempt suicide
- ❑ Back problems
- ❑ Benign breast lump
- ❑ Bleeding ulcers
- ❑ Bronchitis
- ❑ Cancer
- ❑ Candida infection
- ❑ Cataracts
- ❑ Chest pains
- ❑ Chronic pain
- ❑ Cirrhosis
- ❑ Crohn's Disease
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticulitis
- ❑ Drug addiction
- ❑ Dyslexia
- ❑ Ear infections
- ❑ Eczema
- ❑ Emphysema
- ❑ Endometriosis
- ❑ Excessive fatigue
- ❑ Fainting or dizzy spells
- ❑ Fatigue
- ❑ Frequently ill
- ❑ Gall stones
- ❑ Gastritis
- ❑ Gingivitis
- ❑ Gout
- ❑ Gonorrhea
- ❑ Hay fever
- ❑ Headaches
- ❑ Hearing problems
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated disc
- ❑ Herpes
- ❑ High blood pressure
- ❑ Hives
- ❑ Hypoglycemia
- ❑ Insomnia
- ❑ Irregular heart beats
- ❑ Jaundice
- ❑ Kidney stones
- ❑ Light sensitivity
- ❑ Liver disease
- ❑ Low blood pressure
- ❑ Lupus
- ❑ Major surgery
- ❑ Measles
- ❑ Mononucleosis
- ❑ Multiple sclerosis
- ❑ Nervous breakdown
- ❑ Neuralgia
- ❑ Night blindness
- ❑ Numbness
- ❑ Pancreatitis
- ❑ Persistent cough
- ❑ Pneumonia
- ❑ Polio
- ❑ Psoriasis
- ❑ Rheumatic fever
- ❑ Rheumatoid arthritis
- ❑ Ringing in the ears
- ❑ Scarlet fever
- ❑ Sciatica
- ❑ Skin ulcers
- ❑ Sleep issues/ nightmares
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Ulcerative colitis
- ❑ Vision problems

Other illnesses:

_____

_____

_____

_____

_____

OTHER KNOWN INJURIES THROUGHOUT LIFETIME

Any head injuries or head trauma?

_____

_____

Any car accidents? _____

Have you ever played contact sports (football, soccer, etc.)_____

Have you ever lost consciousness? _____

Do you have any old scars on your head? _____