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NeuroThryve
BIOFEEDBACK, APPLIED PSYCHOPHYSIOLOGY TRAINING AND HEALTH PSYCHOLOGY

New Patient Information

General Information

Last Name: _____ First Name:_____ Middle Initial:____

Date of Birth: _____ Preferred Pronoun:_____ Preferred Name:_____
Home Address:_____

Telephone: H:_____ Cell:_____Work:_____Fax:_____

For routine messages: Phone#:_____ Email:_____

For confidential/private messages: Phone#:_____ Email:_____
How and when do you prefer to be contacted?_____

Is there a form of contact that you prefer **never** be used? If so, what? _____

Emergency Contact:_____Telephone Number:_____Relationship: _____

Red Flag Law: Driver's License Number and State or other photo ID: _____

Referral Information:

Referred by: _____Relationship to patient:_____
Reason for Referral:_____

Primary Care MD: _____ Primary Care MD Telephone:_____

Billing Information:

Responsible party:

_____ Self (information same as above)

_____ Other: Name:_____Relationship to patient:_____

Address:_____

Land line: _____Mobile Phone:_____

Okay to leave a message? ☐ Yes ☐ No

Current Concern Questionnaire

The information you provide in this questionnaire will help bring me up to speed so that I can be an effective part of your treatment team. If you are hesitant to complete any part of this form, please feel free to leave it blank and we will discuss it during our first meeting. It is extensive to save us time, but if you prefer, you may complete the brief intake questionnaire available from the front office or online and we will go over the information in this questionnaire together in session.

The Basics

Identifying Information:

Legal Name:_____ Date: _____

Preferred Name: _____ Preferred Pronoun: _____

Address:_____ Date of Birth:_____

What are your initial concerns for which you seek treatment at this time? What are your goals for each concern?

1. _____

2. _____

3. _____

About You

Gender: ☐ Female ☐ Male ☐ Intersex ☐ Transgender ☐ Other: _____

Relationship Status:

	How Long?		How Long?
☐ Single, never legally married or committed		☐ Separated	_____
☐ Married	_____	☐ Divorced	_____
☐ Coupled	_____	☐ Widowed	_____

With which group(s) do you most identify? (check as many as apply)

☐ African descent	_____	☐ Native American	_____
☐ Asian	_____	☐ Pacific Islander	_____
☐ Euro-American	_____	☐ Southeast Asian	_____
☐ Latina/o	_____	☐ Other:	_____
☐ Middle-Eastern	_____	☐ Other:	_____
☐ Multicultural	_____	☐ Other:	_____

What language(s) do you primarily speak at home? _____

Do you have any religious or spiritual practices? ☐ Yes ☐ No

If yes, please describe:_____
Would you like to have these beliefs and practices incorporated in your treatment? ☐ Yes ☐ No

Education/Academic History:

Highest Level of Education Completed	School Name/Location?	When?
_____	_____	_____

Did you have any learning or behaviour problems in school? If yes, please explain: _____

_____

Are you currently experiencing any of the following stressful situations?

Couples/Relationship stress	☐ Yes	☐ No
Stress at Work	☐ Yes	☐ No
Stress at School	☐ Yes	☐ No
Financial Stress	☐ Yes	☐ No
Stress With Your Family	☐ Yes	☐ No

Which best describes your current living situation?

☐ I live alone ☐ I live with other people. Please list those with whom you live, including pets:

Name	Age	Relationship

How has the concern that brings you to seek treatment been affected by your home situation? How has your home situation been affected by this concern?

_____

_____

_____

_____

_____

_____

_____

Which best describes your current employment situation:

☐ Employed full-time	☐ Military, Active duty	☐ Employed part-time
☐ Full-time student	☐ Part-time student	☐ Homemaker, caregiver
☐ Volunteer	☐ Retired	☐ Retired
☐ Disabled due to: _____		☐ Unemployed due to health problems
☐ Unemployed for other reasons: _____		

If employed, please indicate:

Job Title: _____

Responsibilities: _____

Current Level of Satisfaction ☐ High ☐ Moderate ☐ Poor

Level of Satisfaction Prior to Your Current Concern ☐ High ☐ Moderate ☐ Poor

Do you receive any of the following?

	Related to your health or pain condition?	
☐ SDI (State Disability Insurance)	☐ Yes	☐ No
☐ SSI (Supplementary Security Income)	☐ Yes	☐ No
☐ Worker's Compensation	☐ Yes	☐ No
☐ Unemployment Insurance	☐ Yes	☐ No

Please describe your habits as indicated below:

In a typical week, how many days did you exercise? _____ days

For how long do you exercise per day? _____ minutes per day

In a typical week, how many days did you consume alcohol? _____ Days

In a typical day, how many drinks do you consume? _____ drinks
(1 drink = one 12 oz beer, 4 oz wine, or 1 oz hard liquor)

Have you ever participated in a substance abuse program? ☐Yes ☐ No

If yes, which one? _____

In a typical week, how many days did you restrict your eating? _____ days

In a typical week, how many days did you eat significantly more than you intended? _____ days

Have you ever participated in an eating disorders program? ☐ Yes ☐ No

If yes, which one? _____

How much nicotine do you use in a day?_____in a day. Please indicate which ones:

☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Pipe ☐ Nicotine patch ☐ Nicotine gum

When did you start using nicotine? _____

How much caffeine do you use in a day?_____ in a day. Please indicate which ones:

☐ Coffee ☐ Colas ☐ Chocolate ☐ Mello Yello/Mountain Dew, etc.
☐ Teas ☐ Energy Drinks ☐ Other:_____

Please describe your usual sleep patterns:

In general, how many hours of sleep do you get per night? _____ hours

Do you ever stop breathing, or has someone told you that you stop breathing when you sleep? ☐ Yes ☐ No

Has anyone told you that you snore or have you awakened yourself at night with your own snoring? ☐ Yes ☐ No

Usual sleep patterns (continued):

In what position do you sleep? (Check all applicable answers):

☐ On my back ☐ On my stomach ☐ On my side ☐ I change positions often

How do you feel when you first wake up?

☐ Refreshed and rested ☐ Somewhat tired or groggy ☐ Very tired or groggy

Do you find yourself nodding off during the day or taking naps? ☐ Yes ☐ No

Have you had a sleep study done? ☐ Yes ☐ No
If 'yes,' what were the findings? _____

_____

Developmental History: Please indicate what you know of your birth and history below

Prenatal and Birth	Yes	No	Details
Prenatal stress or injury			
Prenatal drug or alcohol exposure			
Birth trauma (forceps, breech, etc.)			
Anesthesia, pain medications			
Anoxia (oxygen deprivation at birth)			
Premature or late delivery			
Medical problems after birth			
Birth Weight			
Other			

Growth and Development	Typical	More	Less	Details
Activity Level				
Motor coordination and development				
Infections and/or allergies				
Emotional development				
Behavioral concerns				
Development of handedness				
Appetite, digestion				
Language, speech development				
Other:				
Other:				

Physical Traumas	Yes	No	Details
Head injury (including minor falls)			
Coma, loss of consciousness			
Accidents (list all)			
Abuse (list all)			
High fever(s)			
Serious illness			
Surgeries			
Central nervous system infection(s)			
Drug overdose or poisoning			
Recreational drug use			
Anoxia (oxygen deprivation)			
Stroke			
Other			

Stress and Life Changes	Yes	No	Details
Death(s) in family			
Divorce, break up of committed couple			
Remarriage, recoupling			
Moving, relocating			
Changing schools			
Changing jobs			
Chronic illness or pain			
Chronic illness or pain in family member			
Other			

Do you now have, or have you ever had:

Condition	I currently have (when diagnosed?	I have had in the past (indicate dates)	My family members have (indicate relationship of person with the condition)
High blood pressure			
Low blood pressure			
Heart disease			
Mitral valve prolapse			
Other heart murmur			
Heart arrhythmia			
Angina			
Functional cardiac pain			
Anemia			
Stroke			
Transient ischemic attacks			
Fainting (syncope)			
Dizziness (vertigo)			
Raynaud's disease			
Menstrual irregularities			
Hemophilia			
Tingling in hands or feet			
Cancer:			
Diabetes (insulin dependent)			
Diabetes (non-insulin dependent)			
Gastroparesis			
Irritable bowel syndrome (IBS)			
Repetitive abdominal pain (RAP)			
Colitis			
Gastritis			
Ulcer			
Heartburn			
Eating disorder			
Headache			
Migraine			
Tinnitus			
TMJ or bruxism			
TMD			
Repetitive strain injury (RSI)			
Chronic back pain			
Other chronic pain:			
Allergies:			
Sinus pressure or pain			
Dermatitis			
Psoriasis			
Eczema			
Muscle spasms			
Arthritis			
EB Virus (Mono)			
Chronic tiredness			
Shortness of breath			

Do you now have, or have you ever had (con't):	I currently have (when diagnosed?)	I have had in the past (indicate dates)	My family members have (indicate relationship of person with condition)
Emphysema			
Hyperventilation			
Asthma			
Panic attacks			
Post traumatic stress disorder			
Depression			
Hyperthyroid			
Hypothyroid			
PMS			
Chronic vaginal yeast			
Cystitis			
Herpes			
Painful intercourse			
Erectile dysfunction			
Prostate problems			
Difficulty having orgasms			
Plantar fasciatis			
Other foot pain:			
Anxiety			
Anger/Rages			
Attention Problems			
Hyperactivity			
Memory Problems			

Please indicate any concerns you have *other than those that bring you here today*:

Concern	Current Status	Current Treatment(s)	Health Care Professional

Are you allergic to: Rubbing alcohol ☐ Yes ☐ No Bandaids ☐ Yes ☐ No

Have you ever participated in, learned, or performed:

A sport: _____ A martial art: _____

Dancing: _____ Music: _____

About The Primary Concern That Brings You to Treatment Now

How long have you had trouble with this concern? _____

Which of the following best describes how this difficulty began:

☐ Accident at Home
☐ Accident at Work
☐ Work Related
☐ After a Trauma
☐ Motor Vehicle Accident
☐ After An Illness
☐ After A Head Injury
☐ Have had as long as I remember
☐ After Surgery
☐ Just Began
☐ Came on Gradually

What is your understanding of what is causing this problem?

_____

_____

Are there any events or circumstances that you think may have contributed to this problem beginning? (stressful events, trauma, menarche, accident(s), pregnancy, exertion, other)

_____

_____

_____

Please describe any periods of time in which your concern either significantly diminished or worsened:

_____

_____

_____

Is there a Worker's Compensation claim or litigation involved with your case?

- ☐ No
- ☐ No, but claim or litigation is being considered
- ☐ Yes, but already settled. Date: _____
- ☐ Yes, currently involved:

  Attorney Name: _____ Telephone: _____

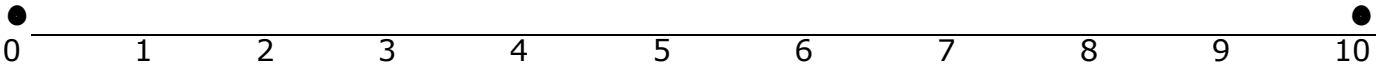
  Address: _____

  _____

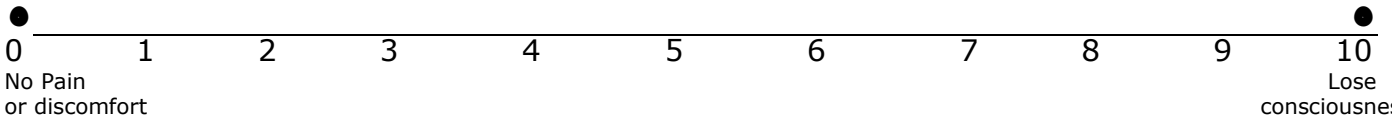
  Worker's Comp Company: _____ Telephone: _____

  Claim Adjuster: _____ Telephone: _____

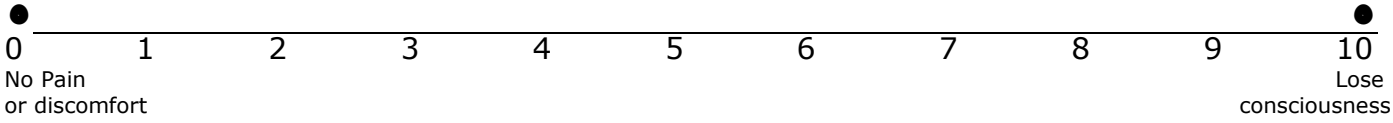
On the scale below, please circle the number that best describes your discomfort from this concern on an average day where 0 = No pain, distress, or discomfort at all and 10 = Pain or discomfort is so intense that you lose consciousness after just a few minutes.



Please circle the number that best describes your pain, distress, or discomfort from your concern on a bad day:



Please circle the number that best describes your pain, distress, or discomfort from your concern on a good day:



In the past week how many bad days have you had? _____ bad days

In the past week how many good days have you had? _____ good days

Are you aware of any of the following factors relieving your concern?

	Never	Rarely	Sometimes	Usually	Always
Take medication					
Massage					
Change position					
Lie down					
Exercise					
Sexual activity					
Drink fluids (water, juice)					
Pressing on area					
Drink alcohol					
Use cannabis					
Take other drug, heat packs					
Hot bath or shower					
Ice or ice packs					
Distracting activity					
Rest					
Eat					
Other:					
Other:					
Other:					
Other:					

Are you aware of any of the following factors triggering or aggravating your concern?

	Never	Rarely	Sometimes	Usually	Always
Food					
Hunger					
Alcohol					
Smoking					
Exercise					
Sexual activity					
Fatigue					
Pollen count					
Jaw clenching					
Neck movements					
Coughing					
Sneezing					
Life Stress					
Relaxation					
Anxiety					
Depression					
Anger					
Flicker					
Glare					
Eyestrain					
Noise					
Humidity					
High temperature					
Low temperature					
Other:					
Other:					

During the past month, how much did your concern interfere with the following activities:

	Not at all	A little	Moderately	A lot
Going to work				
Performing household chores				
Doing yard work or shopping				
Socializing with friends				
Participating in recreation				
Having sexual relations				
Physically exercising				
Sleeping				
Eating				
Other important activity:				

	Never	Sometimes	Frequently	Always
How often do you lie down because of your concern?				
When your concern is interfering significantly in your life, how often i your significant other/family member/friend supportive and encouraging?				
When your concern is interfering significantly in your life, how often does your significant other/family member/ friend ignore you or become angry?				
How often has there been conflict or disharmony between you and your significant other/familymember/friend since the start of your concern?				

Does this problem ever disturb your sleep? If yes, please indicate how:

- ☐ Delay getting to sleep
- ☐ Awaken early in the morning
- ☐ Awaken during the night
- ☐ Does not disturb sleep

List all current prescription and over the counter medications taken for this condition:

Medication	Dosage (Per Day)	Side Effects (if any)	How Effective Is It?	Prescribed By

List all current prescription and over the counter medications taken but unrelated to this condition:

Medication	Dosage (Per Day)	Side Effects (if any)	Reason for Prescription	Prescribed By

List all vitamin supplements or herbal remedies you are currently taking for any condition:

Vitamin supplement or herbal remedy	Dosage (Per Day)	Reason You Are Taking This Supplement or Remedy	Recommended or Prescribed By

Please indicate other treatments you have tried and indicate their effectiveness:

Treatment	Currently Trying	Tried In The Past	Lasting Benefits	Temporary Benefits	No Effect At All	Condition Worsened
Acupressure						
Acupuncture						
Alexander Technique						
Bioenergetics						
Biofeedback						
Qi Gung						
Chiropractor						
Cranial-Electrotherapy Stimulation (CES)						
Cranio-sacral						
Egoscue Method						
Exercise						
Feldenkrais						
Flower Essences						
Hanna Somatics						
Healer (alternative)						
Heat						
Ice						
Guided Imagery						
Herbal Remedies						
Homeopathy						
Hypnosis						
LENS						
Massage						
Medicine Man						
Microcurrent Electrical Therapy (MET)						
Myotherapy						
Nerve Blocks						
Neurofeedback						
Physical Therapy						
Psychotherapy						
Relaxation						
Meditation						
Mindfulness						
Shaman						
Somatic Experiencing						
T'ai Chi						
Therapeutic Touch						
Yoga						
Other:						
Other:						
Other:						

Please indicate below how satisfied you are with the diagnosis and treatment of this condition:

	Very Satisfied	**Somewhat Satisfied**	**Somewhat Neutral**	**Very Dissatisfied**	**Dissatisfied**
My health care provider's diagnosis of my condition	☐	☐	☐	☐	☐
My health care provider's treatment of my condition	☐	☐	☐	☐	☐
The benefits and side effects of my current medication(s)	☐	☐	☐	☐	☐
The overall medical care of my health or pain condition	☐	☐	☐	☐	☐

Please check the box(es) that best describes your current attitude towards your concern and your treatment:

- ☐ I believe there is a medication or other medical treatment that will cure all or most of my concern.
- ☐ I am not sure if there is anything that will cure all or most of my concern.
- ☐ I believe I may have this concern for a long time, perhaps for the rest of my life.
- ☐ My thoughts, emotions, and behaviors have little or no influence on my concern.
- ☐ My thoughts, emotions, and behaviors have some impact on my concern.
- ☐ I can modify my concern by changing my thoughts, managing my emotions, or changing my behaviors.
- ☐ I am basically satisfied with my current medications for my concern and want to continue taking them.
- ☐ I am wondering if my medications are really all that helpful.
- ☐ I am interested in changing my current medications for my concern.
- ☐ I am interested in stopping or decreasing my current medications for my concern.
- ☐ I am *not* interested in learning or practicing self-management, non-medication methods to manage my concern.
- ☐ I would like to get some training or suggestions on how to best self-manage my concern

Other observations, notes, or comments (optional):

Please keep track of how you eat for the week prior to our meeting on this diary form, or on another of your choosing that contains at least the same information.

Food Diary

Name of Meal/Snack	Food Eaten	Amount	Time of Day

Please keep track of your concern and any symptom experiences from now until the time we meet on this diary form, or on another of your choosing that contains at least the same information.

Symptom Diary

Date	Time	Symptom Severity Rating (0=None, 10=Lose Consciousness)	Action Taken To Get Relief	Effect
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		

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Fees

My practice is private pay which gives us the freedom to focus on issues that are important to you and use empirically validated and empirically supported treatments that are likely to benefit you without the limitations imposed by health insurance and managed care.

Payment is required at the time of service as we are unable to bill for sessions at this time. Consequently, the fees listed below reflect a discounted rate. Please do plan to pay when you arrive for your appointment with cash, check, Health Savings Account (HSA), or credit card. You will be provided with a receipt. If you wish to bill your insurance company for reimbursement, please let our patient services staff know and after your appointment they will create documentation that you can submit to your insurance company.

Regular Fees

- Individual intake session without biofeedback: $225
- Individual initial assessment using physiological monitoring and biofeedback equipment: $350
- Individual follow-up 60-minute session: $160
- Individual follow-up 45-minute session: $140
    - Individual health psychology 12 session pre-paid package:
        - $130 for each 60-minute session
        - $120 for each 45-minute session
- Individual follow-up: 30-minute session $100
- Biofeedback training (peripheral) with psychotherapy: $50 for each 15-minute unit, most sessions running 30-60 minutes
    - Individual follow up biofeedback training 6 sessions prepaid: $40 for each 15-minute unit, most sessions running 30-60 minutes.
- High Performance Neurofeedback with psychotherapy - $50 for each 15-minute unit, most sessions running 30-60 minutes.
    - High Performance Neurofeedback 12 or 24 sessions pre-paid: $40 for each 15-minute unit, most sessions running 30-60 minutes.
- Testing with provider, paper-and-pencil measures, or by computer: $175/hour, with most testing charges (includes costs of tests, administration, scoring, interpretation) running $400-$800.
- Other services: consultations, letter writing, report writing, telephone calls, emails, etc. are $50 for each 15-minute unit.

Reduced Fees

I am able to offer a very limited number of lower fee slots for individuals challenged with chronic medical conditions or chronic pain and living on fixed incomes that cause financial hardship that may limit their ability to access services. Completion of a reduced fee agreement is required. Appointments are subject to availability.