Neurofeedback Intake

Personal Information

Patient Name:

_____

Parent Name (For children only):

_____

Full name _____Name you wish to be called_____

Street Address _____

City _____ State _____ Zip _____

Phone: H) _____ W) _____

E-Mail: _____

Date of birth ____/____/____ Gender: M / F

Occupation: _____Employer: _____

Who were you referred by? _____

Person to contact in case of emergency _____ Phone _____

Primary Concern

Please briefly describe the presenting problem including date of onset and severity of symptoms.

_____

_____

_____

_____

What are you hoping to gain from neurofeedback? Please specify target symptoms/behaviors.

_____

_____

Have you been diagnosed with a developmental disability? If yes, what is the diagnosis?_____

Developmental

Are you aware of any prenatal/birth events or injuries such as maternal stress, accident, drug exposure, difficult labor, forceps delivery, breech birth, induced labor, pitocin, anesthesia, anoxia, premature/late delivery or post birth problems? Other? Please describe.

_____

_____

_____

_____

Problems with growth/development such as severe or recurrent illnesses or infections, allergies, emotional difficulties, behavioral problems, appetite/digestion, language/speech, coordination? Walking/talking early or late? History of ear infections? Please describe.

_____
_____
_____
_____

History of physical trauma, injury, head injury, TBI, coma, accidents, high fever, serious illness, surgery, CNS infection, poisoning, anoxia, stroke or heart attack? Broken nose?

_____
_____
_____
_____

Health

List <u>current</u> health issues & problems:

_____
_____
_____
_____

List other practitioners seen, treatments, self-care activities, and results:

_____
_____
_____
_____

List all surgeries you have had, with dates and results:

_____
_____
_____

Have you ever been in an accident or seriously injured? (if so, please describe)

_____
_____

Do you have any dental or TMJ problems? Y N (if so, please describe)

_____
_____

Have you had your wisdom teeth or other teeth removed? Y N *Have you ever had a root canal? Y N (if yes note which teeth) _____

List all medications, vitamins, herbs and other supplements you are now taking, the dose, and reason for taking:

_____

_____

_____

List all medications and other substances (i.e.: foods) to which you are allergic:

_____

_____

_____

*Describe your use of: Cigarettes/Tobacco _____Alcohol _____Other drugs_____

*Describe your present exercise habits including frequency per week, duration, and heart rate:

_____

_____

How many hours per night do you sleep? ____

Do you fall right asleep? Y N

Do you wake up feeling refreshed? Y N

Do you sleep through the night without waking? Y N

Do you remember your dreams? Y N

Do you snore? Y N

Do you have night sweats? Y N

Do you have nightmares? Y N

Do you grind your teeth at night (bruxism)? Y N

Do you have restless legs (RLS)? Y N

Nutrition

How much do you drink each day (8oz): Water:____ Juice: _____ Soda Diet: ____ Soda Regular: ____

Coffee: Regular: ____ Decaf: ____ Tea: Regular:____ Tea Sweet :____ Energy Drinks/Other:_____

List oils or fats that you use in cooking:

_____

Do you frequently skip meals? Y N Are you on any special diet or nutrition program? Y N

Describe:

_____

Are you allergic or sensitive to any foods? Y N If yes, name the foods and describe the problem.

_____

What foods do you dislike? _____

What is/are your favorite food(s)?_____

Circle the foods you crave:

Meats Fats Sweets Salty foods Vegetables Fruits Breads Fatty foods Spicy foods Sour foods Cereals Dairy
Other individual _____

Do you use: (circle) butter margarine shortening coconut oil

Do you eat organic foods? Y N

Do you know what partially hydrogenated fats are? Y N _____

If yes, do you eat them? Y N

Do you eat from fast food restaurants? Y N -- If yes, how often? _____

What do you usually eat for breakfast?

_____

What do you usually eat for lunch?

_____

What do you usually eat for dinner?

_____

What do you usually eat for snacks (in between meals and/or before bed)?

_____

What foods do you eat a lot of (at least once a day, every day)?

_____

How many bowel movements do you have per day? _____

Type of sport/activity/exercise routine you participate in: _____

Hours you train/exercise average per week: _____

Do you train by yourself or with others? (circle)

Do you use a heart rate monitor? Y N

Educational Information

Do you currently or have you ever received any assistance in school/have an IEP/504 plan? Please describe.

_____
_____
_____
_____

Do you receive any interventions such as PT/OT/speech, etc.?

_____
_____

Have they had developmental/psychiatric testing? Yes ____ No _____
If yes, what were the results of that testing.

_____
_____

Are any of the following symptoms present?

☐ Inattention ☐ Daydreaming ☐ Poor concentration ☐ Lack of motivation	☐ Hyperactivity after sugar ☐ Hyperactivity after sedatives ☐ Overwhelmed by stimuli	☐ Impulsivity ☐ Distractibility ☐ Stimulus seeking ☐ Thrill seeking ☐ Competing thoughts; too many thoughts

	☐ Disorganized ☐ Hard to make decisions (executive functions)	

Psychological Information

Are you currently in mental health counseling? Yes_____ No_____

Have you ever been in mental health counseling? Please note the time frame & reason.

_____

_____

_____

_____

Are any of the following symptoms present?

☐ Anxiety (worry) ☐ Depression (blue, low, hopeless) ☐ Irritability ☐ Feelings easily hurt ☐ Perfectionist ☐ Remorseful after tantrums ☐ Cries easily (Feelings hurt) ☐ Rumination ☐ Guilt ☐ Withdraws when stressed ☐ Passive ☐ Wishes was dead ☐ Grumpy ☐ Thinks little of self ☐ Performance anxiety ☐ Shy ☐ Seasonal affective disorder	☐ Binge eating ☐ Anorexia ☐ Bulimia ☐ Panic attacks ☐ Encopresis (soiling) ☐ Irritable bowl syndrome ☐ Rages	☐ Anxiety (fear) ☐ Depression (agitation) ☐ Agitation ☐ Mania ☐ Paranoia ☐ Suidical thoughts or actions ☐ Shame ☐ Compulsive behavior ☐ Involuntary movements or tics ☐ Impatient ☐ Aggressive; initiates conflict ☐ Jealous, envious ☐ Angry ☐ Lacks remorse ☐ Hates self ☐ Dissociative ☐ Exhausted ☐ Lacks empathy ☐ Lacks cause and effect

☐ Fidgets ☐ Whining ☐ Tired, listless ☐ Obsessive thoughts		thinking ☐ Manipulative, controlling ☐ Holds a grudge ☐ Poor comprehension and expression of emotions ☐ Lacks body awareness (Pain, discomfort, appetite) ☐ High pain threshold ☐ Loud, unmodulated voice ☐ Poor eye contact ☐ Poor social awareness

Do you identify any history of trauma? History of physical/sexual/emotional abuse? Feel free to circle.

_____

_____

Do you have a strained relationship with your mother or father? Briefly describe.

_____

_____

Do you feel as though you have a support system? This can include family, friends, faith based organizations.

_____

_____

Office Policies

Scope of Practice
Dr. Luke Pietrantone and Dr. Michelle Pietrantone are Chiropractors, and not medical or osteopathic physicians. As a result, this practice and the care provided are limited to that which is permitted by State Law. We do not provide the type of care or treat conditions that fall within the scope of practice of Medical Doctors, and do not treat or offer cures for diseases or illnesses, only nutritional advice or support. It is understood that this advice and support is provided for general health and is not offered as treatment for a specific disease or illness.

Psychotherapy and Neurofeedback Services
Rebecca Greiner, LMSW, provides psychotherapy and neurofeedback services within the parameters of New York State regulations. Please note that we do not provide any diagnostic services or mental health diagnoses. These services are intended to support your mental and emotional well-being but are not covered or reimbursable by insurance. Clients seeking these services should understand that payments will be required out-of-pocket. Please inquire about the current rates for psychotherapy and neurofeedback services when scheduling.

Financial Policies
Dr. Luke and Dr. Michelle Pietrantone do not participate (are not in-network) with any insurance. Upon request at the front desk, we will provide you with a receipt that includes the appropriate diagnosis and procedure codes. However, we are unable to fill out any paperwork for approvals, authorizations, or similar requests. Patients may opt to submit this information to their insurance on their own. Any potential reimbursement depends solely on your insurance plan's coverage and limitations.

All payments for appointments are due at the time of the visit. We accept all major credit cards, FSA cards, HSA cards, cash, and checks.

All supplements and additional supplies are the patient's responsibility, and payment for these items is due at the time of the visit.

Cancellation Policy
Please give our office at least 24 hours advance notice for any cancellations. If 24 hours notice is not given, 50% of the appointment fee will be billed to you. You will not be able to schedule subsequent appointments if you have an outstanding no-show balance.

Emergencies
If you have a medical emergency and are unable to contact us through the office phone, 716-655-1421, please go to the Emergency Room or dial 911.

For mental health emergencies, please contact **Crisis Services in Buffalo** at 716-834-3131. This service is available 24/7 and can provide immediate assistance in cases of mental health crises, suicidal thoughts, or other urgent emotional distress. For further support, you may also call the National Suicide Prevention Lifeline at **988**.

Confidentiality
We will never sell your information such as emails or phone numbers. Any requests for documentation by doctors, family members, or insurance companies will require your written consent.

By signing below, you understand and agree to the above office policies, including the 24-hour cancellation fee. Please bring this form to your first appointment. We cannot begin treatment without it.

Name (printed) _____

Name (signed) _____

Date_____