



INTAKE QUESTIONNAIRE Date _____

PATIENT INFORMATION

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

PARENT(S) OR GUARDIAN(S) OF MINOR

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

PLEASE DESCRIBE YOUR COMPLAINTS (WHY YOU ARE HERE?)

WHAT BENEFITS DO YOU HOPE TO GAIN FROM NEUROCORE THERAPY?

PATIENT NAME _____ DATE _____

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

<input type="checkbox"/>	ADD	<input type="checkbox"/>	Seizure Disorders such as Epilepsy	<input type="checkbox"/>	Alzheimer's
<input type="checkbox"/>	ADHD	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Cognitive Impairment
<input type="checkbox"/>	Traumatic Brain Injury	<input type="checkbox"/>	Bipolar Disorder	<input type="checkbox"/>	Stroke or Transient Ischemia
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Tourette's	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Sleep Disorder	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Post Traumatic Stress Disorder
<input type="checkbox"/>	Irritable Bowel	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Chronic Pain
<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Reflex Sympathetic Dystrophy (RSD)	<input type="checkbox"/>	Obsessive Compulsive Disorder

Please indicate any other pertinent diagnosis that is not list 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, BURNING, OR CRAMPING SENSATIONS, THEN PLEASE COMPLETE THE DIAGRAM BELOW

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

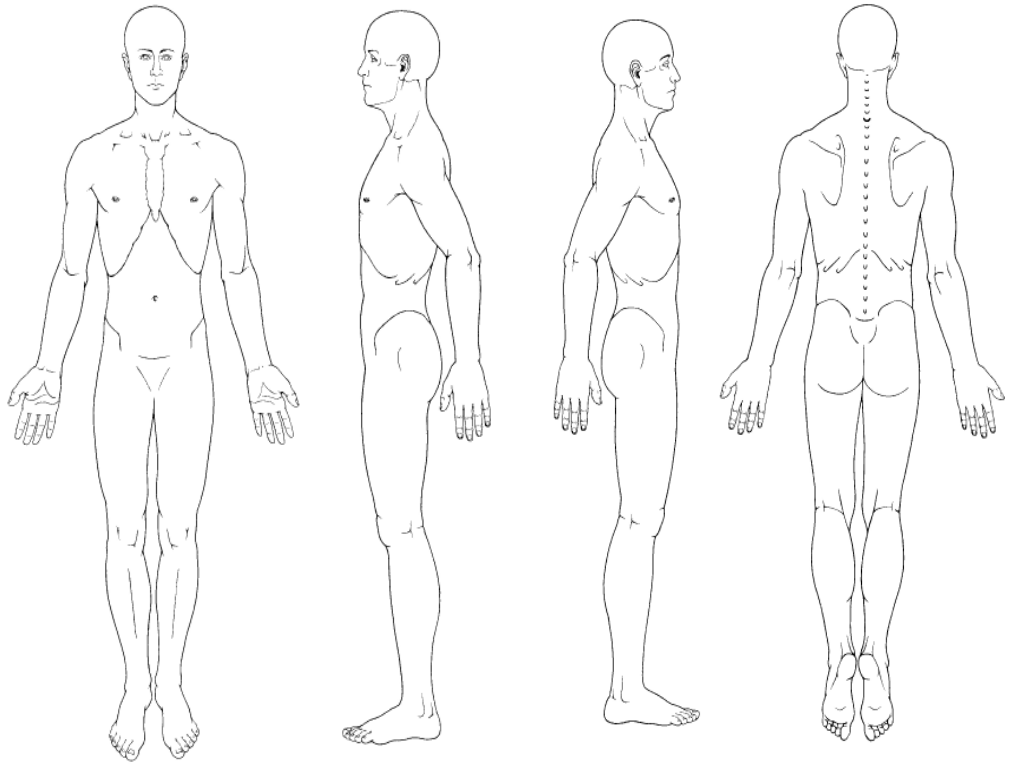
PPP = pain

NNN = numbness

TTT= tingling

BBB= burning

CCC= cramping



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

PATIENT NAME _____ DATE _____