CLARITY
DIRECT NEUROFEEDBACK

# New Client Form

Your Name: (required)

DOB:

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Age: (required)

Gender: (required)

Male Female

Parent or Guardian:

Phone Number: (required)

Work Number:

Your Email: (required)

Address: (required)

Emergency Contact:

Occupation:

Marital Status:

Yes No

How did you hear about this clinic?

Who were you referred by?

Primary reason for seeking treatment? (required)

Additional reasons for seeking treatment?

Is there a family history of your problems?

○ Yes ○ No

Select any of the following that apply to you or members of your family:

☐ Thyroid Disease ☐ Kidney Disease ☐ Asthma ☐ Neurological Disease ☐ Infectious Disease ☐ Diabetes ☐ Cancer ☐ Gastrointestinal Disease ☐ Prostate Problems ☐ Glaucoma ☐ Epilepsy ☐ Other

Do you have a history of:

☐ Traumatic brain injury ☐ Seizures ☐ Migraines ☐ Insomnia ☐ Eating problems ☐ Hormonal issues ☐ Chronic pain ☐ Chronic fatigue ☐ Fibromyalgia ☐ Chronic Lyme's diagnosis

Identify other chronic illnesses you may have:

Do you use any of the following substances?

☐ Caffeine ☐ Tobacco ☐ Alcohol ☐ Illicit Drugs

If so, provide us with the type, amount, frequency and how long you have been taking the substances?

Do you get regular physical exercise? If so, what type and frequency?

Do you practice relaxation or meditation? If so, what type and frequency?

Current Medications:

(Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements. Also include strength & number of pills per day and how long you have been taking the medication)

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