

**Steven M. Rosman, Ph.D., L.Ac., M.S., F.A.A.I.M.**  
NYS Licenses • #001358 and #002433-1  
*Nutrition, Acupuncture, Biofeedback, Stress Management*  
*Mental Health Counseling, Pain Management*  
**2 ProHealth Plaza, Lake Success, NY 11042**  
Phone: 516-608-2806 Fax: 516-608-6877  
Email: [srosman@prohealthcare.com](mailto:srosman@prohealthcare.com)

**BIOFEEDBACK/COUNSELING INTAKE**

DATE:

NAME:

STREET:

CITY: STATE: ZIP:

PHONE NUMBER: (Home) (Cell) (Email)

**PERSONAL DATA:**

A. DATE OF BIRTH:

B. ARE YOU MARRIED:

C. OCCUPATION: WORK PHONE NUMBER:

D. HEIGHT/WEIGHT:

**FOR OFFICE USE ONLY. ASSESSEMENT:**

E. ALLERGIES TO ANYTHING (INCLUDING MEDICATIONS, FOODS, PETS, POLLEN, AND ANYTHING ELSE YOU KNOW):

F. DO YOU SMOKE: YES/NO IF SO, HOW MUCH DO YOU SMOKE?

G. DO YOU DRINK ALCOHOLIC BEVERAGES: YES/NO IF SO, HOW MUCH DO YOU DRINK?

H. HISTORY OF ANY ADDITIONAL SUBSTANCE ABUSE: YES/NO IF YES, PLEASE SPECIFY

I. HIGHEST LEVEL OF EDUCATION (CHECK APPROPRIATE RESPONSE):

\_\_\_ HIGH SCHOOL \_\_\_ 2 YR. COLLEGE \_\_\_ 4 YR. COLLEGE \_\_\_ GRADUATE: \_\_\_\_\_

J. COMMUNITY ACTIVITY: (RELIGIOUS INSTITUTION/ COMMUNITY SERVICE/ SCHOOL ACTIVITY, CHARITIES, ETC.)

SOURCE OF REFERRAL TO MY OFFICE:

MEDICAL SUPERVISION (please list your physicians and all other healthcare professionals along with their phone numbers):

WHAT HAVE YOU OR YOUR PHYSICIANS DONE UP TO NOW TO TREAT YOUR CHIEF COMPLAINT(S). ALSO, PLEASE TELL ME WHAT HAS HELPED:

MEDICATIONS (Please list your medications and the reasons for taking them. Make sure that you provide the doses and proper spelling for each medication):

VITAMINS, MINERALS, HERBS AD OTHER NUTRIENT SUPPLEMENTS (Be precise about spelling and doses):

HOSPITALIZATIONS ( if you can, please list dates, hospitals, and reasons):

PERSONAL MEDICAL HISTORY (check all those applicable to you):  measles  mumps  rubella  polio  
 hepatitis A/B/C (circle the correct choice)  whooping cough  tuberculosis  rheumatic fever  mononucleosis  
 chicken pox  thyroid disease  seizures (the diagnosis was: \_\_\_\_\_)  high blood pressure  
 ear infections  herpes  epilepsy  eczema  cancer (the diagnosis was: \_\_\_\_\_ )  
 diabetes type I/II (circle)  thyroid disease  asthma  heart disease (the diagnosis was: \_\_\_\_\_ )  
 alcoholism  osteoarthritis  rheumatoid arthritis  any gastrointestinal condition (which: \_\_\_\_\_ )  
others (list any others): \_\_\_\_\_

**FAMILY MEDICAL HISTORY (please tell me if there is a family history of any of the following):**

- thyroid disease  seizures (the diagnosis was: \_\_\_\_\_)  
 high blood pressure  arthritis  depression  ulcers  anemia  
 sickle cell anemia  anxiety  allergies  cancer (the diagnosis was: \_\_\_\_\_)  
 alcoholism  diabetes type I/II (circle)  thyroid disease  colitis  irritable bowel  
 other gastrointestinal conditions(list other conditions: \_\_\_\_\_)  
 asthma  heart disease (the diagnosis was: \_\_\_\_\_)  
 others (list any others: \_\_\_\_\_)

**LIFESTYLE:**

DO YOU EXERCISE REGULARLY: IF SO, TELL ME WHAT YOU DO AND HOW MUCH TIME YOU SPEND DOING IT:

DO YOU ENJOY YOUR WORK? HOW MANY HOURS DO YOU WORK PER WEEK ON THE AVERAGE?

DO YOU HAVE PEOPLE WHO SUPPORT YOU?

**SLEEP:**

HOW MANY HOURS DO YOU SLEEP ON THE AVERAGE?

DO YOU AWAKEN FEELING REFRESHED?

DO YOU AWAKEN DURING THE NIGHT? IF SO, HOW OFTEN AND FOR WHAT REASON(S)?

**NEUROPSYCHOLOGICAL:**

Seizures  Areas of numbness: Where? \_\_\_\_\_  Concussion  Poor memory  Depression  Anxiety  Susceptible to stress

Any other emotions or neurological symptoms you wish to discuss?

1. Check those items which apply to you:

Are you exposed to chemical or environmental toxins at work or home:

If so, to what have you been exposed:

Have you had (do you now have) liver or kidney disease?

Please print and sign your name and record the date where indicated below if you agree that the information you have provided in this form is true.

Print your name: \_\_\_\_\_

Sign your name: \_\_\_\_\_ Record the date: \_\_\_\_\_

**FOR OFFICE USE ONLY: PRESENTATION AND TREATMENT PLANS (INFORMATION MAY BE CONTINUED ON THE BACK OF THIS SHEET):**