

Biofeedback/Counseling Intake Form For Minors

Minor's Name _____

Birthdate _____ Age _____

Parents' Names _____

Minor's Address _____

Home Phone _____ Work Phone _____

Beeper/Cellular _____

Names and ages of siblings _____

Primary symptom(s) or complaints: _____

Dates and conditions surrounding first appearance of each symptom:

Does minor have any other health problem (describe)? _____

Minor's Physician (name, address and phone):

Name of person who referred you: _____

Medications and dose (current): _____

Parent's reasons for seeking assessment/treatment _____

School and grade _____

How is minor functioning in school? _____

Hobbies, special interests and skills _____

History of vision, hearing, speech or emotional problems _____

How would you describe minor's relationship with others? _____

Caffeine consumption (coffee, tea, chocolate, colas) occasional daily
 several times a day

Illnesses or significant stresses in the past year _____

Other information you feel may help me _____

Please obtain your diagnosis or diagnoses from your physician(s) with the appropriate diagnosis code written on professional stationery.

For Office Use Only:

Physician's Name: _____ Phone #: _____

Patient's Diagnosis: _____ Dx Code #: _____