# INTAKE FORM

Thompson Neurofeedback
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Neurofeedback and Counseling Services
4230 Gardendale, Suite 502
San Antonio, TX 78229

| Client's Name: First MI Last | Gender: ___Male<br>___Female | Today's Date<br>___/___/____ |
|---|---|---|
| Home Address | Home Phone # ( )<br>Cell Phone # ( )<br><br>Email: ________________________________<br>O.K. To send email? ___Yes ___ No | |
| City: State: Zip: | Date of Birth ___/___/___ | Age: |
| Employer: | Occupation: | |
| Business Address: | Business Phone # ( ) | |
| City: State: Zip: | Social Security # | |
| Relationship Status: _Single _Married _Committed Relationship _Separated _Divorced _Widowed | | |
| Number of persons other than yourself living in house? | Adults: _____ Children ______ | |
| Name of Partner/ Spouse/Parent<br>First MI Last | Date of Birth | Age |
| Employer | Occupation | |
| Business Address | Business Phone # ( )<br>Cell Phone # ( ) | |
| City: State: Zip: | | |

| Children (minor and adult) | Sex | Age | Descriptive Comment |
|---|---|---|---|
| | | | |
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|---|
| Have you experienced any major changes or events in your life during the past year? __Yes __No |
| Have you lost a friend, family member or other significant person during the past year? __Yes __No |
| Are you presently seeing another counselor? __Yes __No, If yes, who? |
| Have you had previous counseling or psychotherapy? __Yes __No, Where and was it beneficial? |

Please Continue on the Reverse

| What brings you to therapy? | |
|---|---|
| Physician: | Phone#: ( ) |
| Are there any health conditions I should be aware of? __Yes __No, If yes, please describe: | |
| Are you currently taking any medications? __Yes __No, If yes, please list and give the reason | |

Thompson Neurofeedback wishes to acknowledge and thank members of the professional community for their trust in referring you to counseling. Your signature below gives permission to make such contact by phone or letter.

Name of Referring Individual:____________________________________________

Street Address_______________________________City____________Zip_______

Phone#_______________________Email____________________________________

Your Signature: __________________________________________________________________

CANCELLATION AND RETURNED CHECK POLICIES

Thompson Neurofeedback charges half the session fee if canceled with less than 24 hours' notice and the full session fee for a missed session due before the next session.
There will be a $25 charge for each returned check or "do not honor"credit card payment
I have read and understand these policies.

Signed:__________________________________________________________________

Date:___________________________