**Brainwave Centre for Education and Therapy – Client Intake Form**

**Name of Client:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Postal Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cell:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent(s) or Guardian(s) of Minor:**

**Name(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address** (if different than above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Postal Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cell:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Professionals Involved in Client Care (teacher, physician, chiropractor, naturopath, etc.)**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Developmental History – Please indicate your (or your child’s) history in relation to the following:**

**Prenatal and Birth Yes No Details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Prenatal stress or injury \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prenatal drug/alcohol exposure \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth trauma (forceps, breech, etc.) \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anesthesia, pain medications \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anoxia (oxygen deprivation @ birth) \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Premature/late delivery \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical problems after birth \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth weight \_\_\_\_\_\_\_\_\_\_\_\_ Adopted at age \_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Growth and Development Typical More Less Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Activity level \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Motor/coordination development \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Infections/allergies \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emotional development \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behaviour concerns \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Handedness development \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appetite/digestion \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language/speech development \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Traumas Yes No Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Head injury (even minor falls, etc.) \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coma (loss of consciousness) \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accidents (list all) \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High fever \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serious illness \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CNS infection \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug overdose/poisoning \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational drug use \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anoxia \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychological Stress/Life Changes Yes No Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Death in family \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Divorce/remarriage \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Move/relocation \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School change \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job change \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family member chronic illness \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptom Checklist**

Please indicate if the **client** and/or **family member(s)** (parents, grandparents, brothers, sisters, aunts, uncles, and/or children) **currently experience** or have a **history** of any of the following symptoms.

**Symptom** √ **if client** √ **if family** √ **if current Symptom** √ **if client** √ **if family** √ **if current**

Feeling Tense \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Depressed \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Always on the go \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

School/work problem \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Impulsivity \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Hyperactivity \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Attention problems \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Behaviour problems \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Vocal or motor tics \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Sleep problems \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Legal issues \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Headaches \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Feeling lonely \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Frequent illness \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Repetitive thoughts \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Repetitive behaviour \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

**Symptom** √ **if client** √ **if family** √ **if current Symptom** √ **if client** √ **if family** √ **if current**

Shy with People \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Allergies \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Asthma \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Seizures / Epilepsy \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Chronic pain \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Food sensitivity \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Head injury \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Memory problems \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

**Symptom** √ **if client** √ **if family** √ **if current** Inferiority feelings \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Dizziness \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Fainting spells \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Heart palpitations \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Stomach trouble \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Poor appetite \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Picky eater \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Nightmares \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Alcohol/drug issue \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Feeling panicky \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Tremors \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

**Please circle** the **five current problems** listed above which are the **most distressing** to you or your child.

Temper tantrums \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Rages \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Verbal Aggression \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Physical Aggression \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Stubbornness \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Addictions \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Bowel disturbances \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Chronic fatigue/FMS\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

**Symptom** √ **if client** √ **if family** √ **if current**

Suicidal ideas \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

PMS \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Physical abuse \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Sexual abuse \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Over ambitious \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Unable to relax \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Can’t make decisions \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Communication prob. \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Problems at home \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Financial problems \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Any chronic illness \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapist Notes:**