THE NEW JERSEY INSTITUTE FOR NEUROFEEDBACK

NeuroIntegration Therapy

Patient Name: ______________________________________ SS#: ________________________
Parent/ Guardian Name (if a minor)________________________Relationship:_____________
Address ______________________________ City/State/Zip:______________________________
Home Phone:___________________ Cell Phone:__________________D.O.B_______________
Sex: M F Age:_________Email Address:____
How did you hear about our clinic? ____
Primary health challenge:______________________________________ Severity 0-10________
Secondary challenge (if any):____________________________________Severity 0-10________
Medications: ____
Supplements: ____
Please rate the following 0-10 (0= not at all 10=worst you can imagine):

_____ Anxiety _____ Learning Disorder _____ Obsessive Behavior
_____ Depression _____ Unable to Focus _____ Insomnia (all night)
_____ ADD/ ADHD _____ Memory Problems_____ Difficulty Falling Asleep
_____ Fatigue _____ Headaches _____ Difficulty Using Body Parts
_____ Mood Swings_____ Ringing in Ears
_____ Anger _____ Poor Concentration

Do you have family members with any of the above difficulties? Yes____ No____
If so, who?____
Have you had a seizure at any time? Yes_____ No_____ If so, when? ___________
Are your eyes sensitive to light? Yes______ No______
Have you had any head injuries (diagnosed or undiagnosed?) Yes _____ No_____
If yes, please explain____
How many Auto Accidents have you been in? (fender benders count) ______________
Please list any other accidents of falls ____________________________________

____
Please list any surgeries ____

____
What are your expectations with NeuroIntegration Therapy? _________________

____

Consent for Treatment of a Minor

I hereby authorize Rebarber Family Chiropractic Center to administer treatment, as they deem necessary to:

Child'sName:____
Parent/Guardian: ____________________________________ Date: _____________________