

PLEASE COMPLETE THE ATTACHED INTAKE CONSULTATION FORM

NAME

APPOINTMENT DATE AND TIME

NOTICE

Please be aware that insurance companies and other agencies may request copies of this intake form, as well as written session notes from our office, in order for your insurance benefits to be paid. If you **do not** wish this information to be released please see *Page 10*. You will also be asked to sign another release form prior to your initial visit.

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Date: _____

Interviewer: _____

Referred By: _____

Allergies, i.e., medications: _____

1. Name: _____ Male / Female Birth Date ___ / ___ / ___ SS# ___ - ___ - ___

2. Home Address _____ City _____ State ___ Zip _____

Phone (Home) _____ (Office) _____ (Cell) _____ (Email) _____

3. Employer _____ Occupation _____

4. Employer Address _____ City _____ State ___ Zip _____

5. Marital Status _____ Years Married _____ Height _____ Weight _____ Right / Left Handed

6. Spouse's Name _____ Birth Date ___ / ___ / ___ SS# ___ - ___ - ___

7. Spouse's Employer/Address _____ Phone _____

8. Parents (**Father**) _____ (**Age**) _____ (**Mother**) _____ (**Age**) _____

9. Children _____ Sex (M) ___ (F) ___ Location _____

10. Brothers ___ Sisters ___ Location _____

11. Person to contact in emergency _____ Relationship _____
Telephone # () _____ Address _____

12. Hobbies _____

(How do you spend your free time?)

13. Physical exercise _____

(Amount/type & frequency)

NAME _____ DATE _____

Do you have any of these common symptoms? Please note their intensity and frequency. Please include all symptoms, even if you consider them unimportant.

Range: From none (0) to overwhelming (10) – (e.g., 3 – 7)

Frequency: Times a Day (D), Week (W), Month (M), or Year (Y) – (e.g., 3 x D)

PHYSICAL SYMPTOMS Circle Symptom		RANGE OF INTENSITY	FREQUENCY OF OCCURRENCE
1.	Cold hands or feet _____		
2.	Hot or cold spells _____		
3.	Headaches _____		
4.	Neck, shoulder, back or other muscle pain _____		
5.	Pains or tightness in chest or heart _____		
6.	Frequent illness _____		
7.	Sweating hands, feet, etc. _____		
8.	High or low blood pressure _____		
9.	Nausea, vomiting, upset stomach _____		
10.	Diarrhea, constipation _____		
11.	Stomach aches, abdominal pains _____		
12.	Heart pounding, racing, arrhythmias _____		
13.	Muscle twitches or tremors _____		
14.	Nervousness, shakiness, trembling, tremors _____		
15.	Coronary heart disease _____		
16.	Easily fatigued, low energy, burnout _____		
17.	Premenstrual syndrome (PMS) _____		
18.	Pain or sensitivity to light or noise _____		
19.	Dizziness or vertigo or faintness _____		
20.	Coordination problems _____		
21.	Itching, skin disorders _____		
22.	Dry throat or mouth _____		
23.	Teeth grinding or clenching _____		
24.	Frequent urination _____		
25.	Accident, injury prone _____		
26.	Trouble getting your breath _____		
27.	Body numbness or tingling _____		
28.	A lump in your throat _____		
29.	Weakness or heaviness of body _____		
30.	Eating disorders, loss or increase of appetite _____		

31. Loss or excessive interest in sex _____
32. Other pain _____

NAME _____ DATE _____

BEHAVIORAL/EXPERIENTIAL SYMPTOMS Circle Symptom	RANGE OF INTENSITY	FREQUENCY OF OCCURRENCE
----------------------------------------------------	-----------------------	----------------------------

33. Nail biting _____		
34. Having trouble falling or staying asleep _____		
35. Unable to get rid of negative thoughts/ideas _____		
36. Unusual body feelings _____		
37. Anxiety, fear, apprehension, panic _____		
38. Feeling critical of others _____		
39. Nightmares _____		
40. Stuttering, stammering, etc. _____		
41. Trouble remembering things, mind goes blank _____		
42. Worried about sloppiness _____		
43. Feeling easily annoyed, angered, irritated _____		
44. Feeling confused _____		
45. Crying easily _____		
46. Temper outbursts you cannot control _____		
47. Blaming yourself for things _____		
48. Impulsive behavior, emotional instability _____		
49. Fidgety, restless, antsy, impatient _____		
50. Feeling blocked in finishing tasks _____		
51. Feeling lonely, separate, sad _____		
52. Substance abuse – food, alcohol, drugs _____		
53. Worry, concern, feeling serious _____		
54. Feeling no interest in things _____		
55. Feeling guilty, shame _____		
56. Feelings being easily hurt _____		
57. Feeling others are not sympathetic _____		
58. Doing things slowly to be sure they are right _____		
59. Feeling inferior to others _____		
60. Having to double check what you do _____		
61. Difficulty making decisions _____		
62. Wanting to be alone _____		
63. Trouble concentrating, distracted _____		
64. Mood swings _____		
65. Feeling hopeless about the future _____		
66. Feelings of unreality / unusual mental events _____		
67. Depression, withdrawal, procrastination, resistance _____		
68. Feeling self-conscious _____		
69. Talking too much _____		
70. Feeling you are watched or talked about by others _____		
71. Feeling people are unfriendly or dislike you _____		
72. Feeling others are to blame for your troubles _____		
73. Feeling people will take advantage if you let them _____		
74. Feeling something is wrong with your mind _____		
75. Lack of motivation, interest _____		
76. Reduction in accuracy, productivity _____		
77. Sexual shyness – disorders _____		

If you exhibit more than a few of these symptoms, you are experiencing the effects of stress and would benefit from learning to reduce stress and pain.

NAME _____ DATE _____

MEDICAL/PSYCHOLOGICAL

1. Primary symptom (s) complaint (s) for which treatment is desired.
 1. _____
 2. _____
 3. _____
 4. _____

2. Date and conditions surrounding first appearance of each symptom.
 1. _____
 2. _____
 3. _____
 4. _____

3. Who diagnosed symptoms? (Name & Address) _____

 What was diagnosis? _____ When was it diagnosed? _____

4. Past/current medical or psychological problems related to primary symptoms: _____

5. Last thorough physical examination by a physician. _____
 Name of physician _____ Date _____
 Outcome and recommendations _____

6. Dates and outcome of previous medical/neurological workups or interventions (pain/other injections, hospitalizations, surgery, physical or other therapy, brain scan, skull x-ray, clinical EEG or other).

Dates	Kind of Exam or Treatment	Outcome

7. Family physician and other physicians currently treating you (Names, addresses)
 Family Physician _____ Address _____
 Other Treating Physician _____ Address _____

Physician to whom you wish a report sent _____
(Name and Address)

8. Previous/current psychological/psychiatric experience

Psychologist/Psychiatrist	Dates of Treatment or Exam	Diagnosis

Have you ever been hospitalized for psychological reasons? _____ When _____
 NAME _____ DATE _____

9. Current medications (Please list all prescribed medications currently used)

Symptom Being Treated	Name of Medication	Dosage	Frequency of Use	Effectiveness (0 – 10)	Side Effects (0 – 10)	Prescribing Physician	Starting Date

10. Relevant medications used in the past and symptoms being treated.

11. Use of non-prescription medication (e.g., aspirin, Tylenol, decongestants, sleep medications, nasal sprays, inhalers, vitamins, other supplements).

12. Past/current use of stimulants and social drugs (please check and describe frequency).

Alcohol _____ Cigarettes _____ Marijuana _____ Coffee _____ Tea _____ No Doz _____
 Other Substances _____

13. Nutritional habits (detailed description of 1 day's typical meals).

Breakfast _____
 Mid-Morning Snack _____
 Lunch _____
 Mid-Afternoon Snack _____
 Dinner _____
 Evening Snack _____

Use of stress foods – please circle and describe frequency.

Sugar Candy Desserts Soft Drinks Salt Chocolate

How often do you eat out? _____

14. General health (Prenatal & perinatal events with developmental history). Please use reverse side if more space is needed.

Childhood _____

 Adult _____

NAME _____ DATE _____

15. Medical History: Check Symptoms and Disorders

Type	Self	Description or Frequency of Occurrence	Other Family Members
Headaches _____			
Arthritis _____			
Allergies _____			
Asthma _____			
Alcoholism _____			
Diabetes _____			
Epilepsy _____			
High Blood Pressure _____			
Heart Disease _____			
G.I./G.U. Disorders _____			
Cancer _____			
Emotional Problems _____			
Insomnia _____			
Other Symptoms _____			
Other Disorders _____			

Describe any occasions when you have lost consciousness or fainted _____

16. What are your expectations or reactions concerning your symptoms (e.g., optimistic, anxious, guilt, frustrated, angry, hopeless, self-doubt, self-pity, fatalistic, withdrawn, etc.?)

Responses of significant others to symptoms (spouse, family, friends, employer, etc.) _____

GENERAL/PSYCHOLOGICAL

17. Please briefly describe characteristics or personality styles of each (5-10 words):

Spouse/boy friend/girl friend _____

Self _____

- Children
1. _____
 2. _____
 3. _____

Marital and/or family relationships. What are the major stresses in your family life?

Father _____

Mother _____

Do you like your job? School? _____

What are the major stresses in your job? School? _____

How would you describe your relationships with others (friends, employers, employees)? _____

Friends _____

Employers/Employees _____

NAME _____ DATE _____

What words would you use to describe your typical daily mood?

Morning _____

Day _____

Evening _____

18. How well can you relax when you have no special problems? (**rate from 0-10**) _____
How well can you relax when you need to relax? (**rate from 0-10**) _____

19. Do you do anything specifically to relax, i.e., have you any knowledge and/or experience with any of the systematic relaxation techniques, such as meditation, yoga, autogenic training, biofeedback training etc.?

What do you do on a daily basis specifically to relax? When do you do this and how much time do you spend? _____

20. Typical daily schedule (please put in approximate times and describe activities during leisure hours).

Time arising _____

Spouse home from work _____

Dress, etc. _____

Dinner _____

Breakfast _____

Evening activities _____

Work schedule _____

Lunch _____

Go to bed _____

Home from work _____

Go to sleep _____

How many hours per day do you watch television? _____

TO BE FILLED OUT BY THERAPIST

MEDICAL/PSYCHOLOGICAL

1. What emotional feeling is dominant when the symptom is present or most intense? (e.g., **nervousness, worry, fear, anger, frustration, other**) _____
2. Do you have any warning that the symptom is coming on or will increase in intensity (e.g., **feeling nervous, depressed, muscle tension, or other mental or emotional state**) _____
3. What reduces or alleviates each symptom? (e.g., **activity, medication, food, beverages, relaxation, sleep, etc.**) _____
4. What increases the severity of each symptom? (e.g., **foods, stressful situation, activity, medication**) _____
5. Have you noticed any time patterns in relation to the occurrence of your symptoms? (e.g., **time of day/ week/month, sleeping vs. waking, menstrual cycle, seasonal change, weather, etc.**) _____
6. Have you noticed that certain feelings or situations might be associated with the onset of symptoms? (e.g., stressful events, impending social/familial/occupational engagements, etc.) _____

NAME _____ DATE _____

7. How are daily activities limited before/during/following the appearance of each symptom? _____

8. How would your life be different without your symptom (s)? _____

9. What, if any, benefits do you receive from your symptoms (e.g., attention from others, opportunity to take it easy, distraction from personal problems) _____

10. Detailed description of symptom (s) / complaint (s) for which biofeedback training is desired. For each symptom:

SYMPTOM	LOCATION	QUALITY OF PAIN	INTENSITY (0 - 10)	DURATION	FREQUENCY OF OCCURRENCE

11. Do you experience suicidal thoughts? _____

Have you ever attempted suicide? _____

Do you think you might ever attempt suicide? _____

To: Les Fehmi, Ph.D.

You are hereby authorized to release any information regarding my treatment to my insurance company, physician, dentist, psychologist or other professional.

Print Name

Signature

Informed Consent Regarding Your Participation in the Treatment Program

It is important at the outset of your treatment program that you fully understand the nature of your participation. The treatment program upon which you are about to embark consists of learning skills which may help in the long-range development of stress management, symptom control, and optimization of functioning. The clinic provides guidance and permissive conditions for the development of these skills. Generally, your progress in training is related to both the quality and regularity of home practice of skills learned during treatment sessions, as well as the gentle persistence in transfer of these skills to life situations. Although during the process of treatment, medical symptoms may remit and normalization of physical symptoms may occur, this is not due to the direct treatment of your medical symptoms. Rather, symptom mitigation and control occurs as a result of learning to manage stress and reactivity, both by the reduction of external stressors and by developing relaxing habits of attention.

Participation in this treatment program should not be undertaken in lieu of proper medical care. A periodic physical examination, as well as a specific work-up of presenting medical symptoms by one's own physician, is requested of all participants in the training program. Persons under medication agree to remain under the supervision of their prescribing physician. Following the advice of the prescribing physician is particularly important because the effects of relaxation may interact with certain prescribed medication.

I have read and understand the above material.

Signature

Date

Payment of Services

Please read the following and sign below that you understand and agree to the terms set forth.

Professional services are charged to the patient and not to the insurance company. We would like to emphasize that your insurance policy is a contract between you and your insurance company. This office can not accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are ultimately responsible for payment of your account, which is why we request full payment at the time of each treatment session.

We will, of course, provide information to help patients receive maximum allowable coverage under their existing insurance plans. An example of such information is a list of insurance questions you can ask your insurance benefits representative and which are outlined and are at the end of the intake questionnaire.

We fully expect that our treatment will provide positive outcomes for most clients but no guarantees are given or implied.

I understand the foregoing and agree to be responsible for full payment of my account.

Signature

Date

Princeton Biofeedback Center, LLC
317 Mt Lucas Road Princeton NJ 08540
REGISTRATION FORM
(Please Print)

Today's date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is patient under 18? <input type="checkbox"/> Yes <input type="checkbox"/> No		DOB: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	OFFICE USE	
Street address:			SSN:		Home phone no.: ()		
P.O. Box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ()	
Occupation:	Employer:	Employer address:				Employer phone no.: ()	
Are you covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Aetna	<input type="checkbox"/> United Health	<input type="checkbox"/> Other			
Group #	Plan #	ID#					
Subscriber's name:		Subscriber's SSN:	DOB: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:		

IN CASE OF EMERGENCY				
Name of relative:		Relationship to patient:	Home phone ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize the release of any information required to process my claims. I also give my permission to submit payment requests electronically to my insurance company.				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	

