INTEGRATIVE THERAPIES, INC.
7E Oak Branch Drive ● Greensboro ● North Carolina ● 27407

Brief Intake Form for Initial Neurofeedback Consult

Name*: _____ Date of Birth: _____ Gender: _____

Cell phone number: _____ Alternative phone number: _____

Email address: _____

Please share what interests or concerns you have that have lead you to seek information about the neurofeedback services at Integrative Therapies. This may include any physical, emotional or cognitive symptoms you (or your child) are having or diagnoses that you feel are relevant. Outcomes you are looking for with regard to performance or behavior may also be listed:

_____

_____

_____

_____

_____

List any medications that you (or your child, if they are the potential client) are currently taking:

_____

_____

_____

_____

*If you are attending a consult on behalf of another, as a parent or guardian, please list your name and contact information below:

Name: _____ Relationship to potential client: _____

Phone and email if different than above: _____