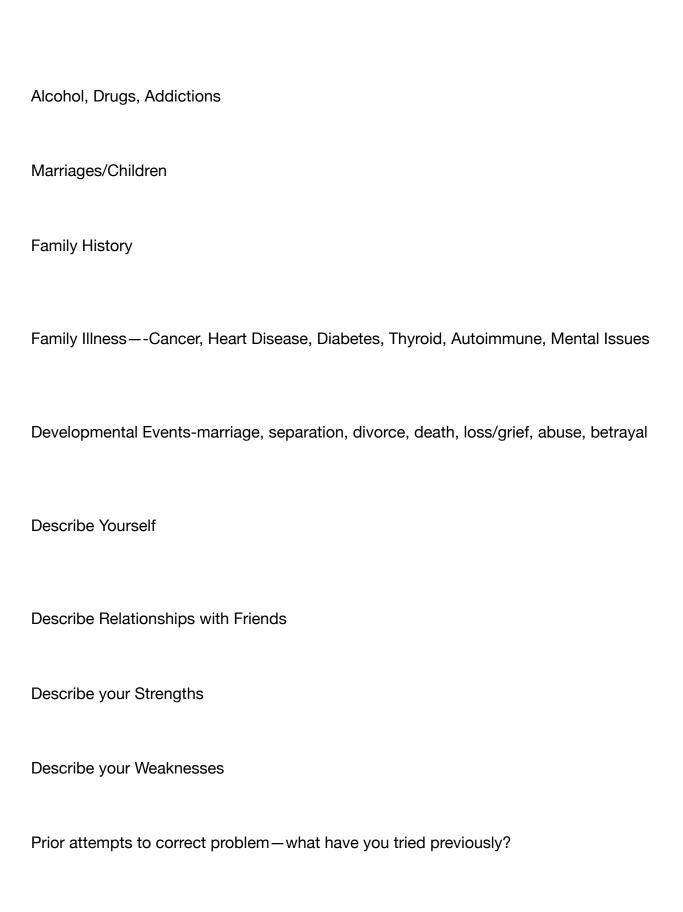
## MicroCurrent Neurofeedback Intake

NAME		
Birth Date	Age	
Address		
Phone	_email	
Occupation		
How did you hear about MC NFB?		
Emergency Contact	Relationship	
Current Life Stressors		
Highest Grade Completed/Degrees/License	s	
Learning Disabilities/Difficulty in School: impulsivity, disorganized, concentration, ADD/ADHD (medication?), difficulty making decisions, easily distracted, anxiety, etc.		
Summary of employment history		
Military History		
Trauma (birth, childhood, adulthood, concussions, etc)		
Summary of Medical History		
Emotional History (anxiety, depression, PTS	D, fear, abuse, eating disorder, OCD, etc.,)	



1		
Medication	Dose	Purpose
List anything else that wo	ould be important to your treatment:	

List 5 main issues that you hope will be reduced or improved by MCNFB. Rate each symptom on a scale of 1 to 10 with 1 being the least (best) & 10 being the most (worst).