DIRECTED WELLNESS CENTER **For Confidential Use Only**

CLIENT INFORMATION SHEET **PLEASE PRINT CLEARLY** **Today's Date:**

Client Name		Age:	Date of Birth:
Address		Email:	
City,State,Zip		Gender: ☐ M ☐ F	Social Security#:
Home Phone _____ Leave Message ☐ Yes ☐ No	Work Phone_____ Leave Message ☐ Yes ☐ No		Cell Phone _____ Leave Message ☐Yes ☐No ☐Text
Occupation:		Employer/School:	
(If Client is a minor) Custodial Parent(s)			
Name:		Name:	
Address:		Address:	
City,State,Zip:		City,State,Zip:	
Phone:	Cell:	Phone :	Cell:
Emergency Contact Information			
Name:		Relation:	
Phone:		Cell Phone:	

Current Couple Status		**Religious Preference**	**Lives with**
☐ Single	Date(s):	☐ Christian	☐ Biological Parent(s)
☐ Engaged	_____	☐ Non-denominational	☐ Foster Parent(s)
☐ Married	_____	☐ Other Protestant	☐ Adopted Parent(s)
☐ Prev. Marr. (s) # ____	_____	☐ Roman Catholic	☐ Spouse
☐ Partnered/Cohabiting	_____	☐ Jewish	☐ Alone
☐ Separated	_____	☐ Muslim	☐ Other _____
☐ Divorced	_____	☐ Buddhist	
☐ Widowed	_____	☐ Other _____	

Family and Household Members

Name	**Relationship**	**Sex**	**Age**	**Living with you?**
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Referral Information, How did you learn of our practice?

☐Directed Minds / Kavanah Client	☐Google Search ☐Yahoo Search	☐ Other Search Engine _____
☐Family Member, Relative, Friend	☐Primary Care Provider	☐ Other _____

Medical/Counseling Information

Primary Physician Name:		**Clinic Name:**	
Phone:	Fax:	Phone :	Fax:
Issues for seeking Neurofeedback Training:		**Expectation from Neurofeedback Training:**	

Previous Counseling Experiences	**Dates**	**Counseling Type**
Provider:		
Provider:		
Provider:		

Health Information

Medication	**Dosage**	**# Per Day**	**Past**	**Present**
			☐	☐
			☐	☐
			☐	☐

Hospitalization/Surgeries	**Dates**	**Where**

Date of Last Physical: