BRAIN
WELLNESS CENTRE

NEW CLIENT FORM

Client Information

First Name Last Name:

Your Phone Number: Email:

Bate of Birth: Gender: Female | Male Dominant Hand: Right | Left

Place of Birth: Current Residence (City):

Please list major moves or immigration from / to:

Education: Years of Education:

Occupation: Hours worked per week: Retired Since:

Marital Status (Please circle): Married Separated Divorced Widowed Single Partnership

Live with (Please circle): Spouse Partner Parents Children Friends Alone

Do you have children? If so, how many? Age(s) of children: Gender of children:

Emergency Contact: Relationship to you:

Phone: Address:

Who reffered you?

Reasons for today's visit:

1. 2.

3. 4.

5. 6.

Signature Date

Personal information will generally be collected directly from you through the use of any of our standard forms, over the internet, via email, or through a telephone conversation with you.

If you access our website, we may collect additional personal information about you in the form of your IP address or domain name. Our website may use cookies from time to time. The main purpose of cookies is to identify users and to prepare customised web pages for them. We may collect and store information about your visit to our website, including the name of the domain from which you accessed the internet, the date and time you accessed the website, the internet address of the website from which you linked directly to the website and the pages you accessed while visiting the website. This information does not in itself identify you and is used to measure the number of visitors to the website and how it was navigated. This information assists us to make the website more useful to you.

We store your personal information in different ways, including in paper and electronic format. We take reasonable steps to ensure the security of all information we collects from risks such as loss or unauthorised access, destruction, use, modification or disclosure of data. For example, your personal information is maintained in a secure environment which can be accessed only by authorised personnel. However, no data transmission over the internet or information stored on servers accessible through the internet can be guaranteed to be fully secure. These activities are undertaken at your risk.

This privacy policy may change from time to time particularly as new rules, regulations and industry codes are introduced.

For more information about The Privacy Act in Canada, you can visit website https://www.priv.gc.ca/en/privacy-topics/privacy-laws-in-canada/the-privacy-act/

Chart Symptoms

Please **check** any of the following symptoms or behaviors that you have experienced **in the past two weeks** and **circle** the symptom that applies the most in each group.

AN		**LD**	
Anxious, uneasy, worried		Confused, mixed up thinking	
Racing thoughts, too many thoughts		Difficulty reading	
Explosive rage/anger, lashing out		Difficulties with math	
Aggressive, hostile, overly assertive		**FI/PA**	
Agitated, upset, disturbed		Teeth grinding, jaw clenching, TMJ	
Hyper focused, "locked in" on one thing		Tic (eye, mouth, other) spasms	
Nauseous, queasy, or upset stomach		Migraine headaches	
CO		Physical tensions in body, taut, tense	
Difficulty making decisions		Pressure in chest, discomfort in chest	
Spacey, foggy, not "tuned in"		Unpleasant physical sensations, pain	
Hyperactive, excessive movement		Tension headaches	
Inattentive, daydreaming, distracted		Crawling sensation on skin, leg twitches	
Impulsive, act without thinking		**ME**	
DE		Difficulty grasping new information	
Feelings easily hurt, overly sensitive		Forgetful, difficulty remembering	
Depressed, hopeless, sad		**IN**	
Cries easily, weepy, prone to tears		Difficulty falling asleep	
Low self-esteem, lacking self-confidence		Disturbed sleep, wake often	
Unable to plan, organize or manage time		Gasping for breath	
Lethargic, drowsy, slow moving		Restless legs	

If you have any additional symptom or concerns, please list them here:

Client Health History

Medical Conditions / Issues: 1. 2. 3.

4. 5. 6.

Surgical History: 1. 2. 3.

Medications (indicate dose): 1. 2. 3.

Hormones: 1. 2. 3.

Supplements: 1. 2. 3.

Please **circle** if you are currently taking any of the following:

Kavinace, GABA, Theanine, 5-HTP, Mucuna powder, Ginko Biloba, Balance D 1-3, Benesom, Brain Calm, Calm-PRT, Deproloft HF, EndoPlus Spray, EndoTrex Spray, ExcitaCor, ExcitaPlus, Lithium Orotate, L-Theanine, Melatonin, Ortho-Sleep, Pure Tranquility, Somnolin, St. John's Wort, Trancor, Tryptophan, Zen-Mind.

What are your health expectations from attending us?

Are you currently undergoing any additional forms of treatment? Please comment:

IV: Chelation:

Psychotherapy/Counselling: Depth Psychology/Analysis:

Physiotherapy: Chiropractor:

Acupuncture: Massage:

Meditation: Hypnosis:

Other:

Have you ever had a concussion, head injury, motor vehicle accident or sporting injury? Please include any history of bumps on the head, falls, fainting, loss of consciousness, whiplash and/or seizure: **Yes / No**

If yes, please list your **age** and describe any **symptoms** you experienced after each incident, and where any injury occurred (bruising, swelling, broken bones, dizziness, loss of consciousness, vertigo, confusion, memory loss, etc.):

Please indicate where your head was hit:

Do you have trouble sleeping? **Yes / No** ; If yes, do you have difficulty falling asleep? **Yes / No** ; Staying asleep? **Yes / No**

What time do you go to bed? What time do you wake? Do you feel rested in the mornings? **Yes / No**

Additional comments:

Please list significant life stressors, when they started and how they manifested?

Please describe in full any obsessive compulsive tendencies you may have?

In the first 10 years of your life, were you ever separated (physically or psychologically) from your mother? (traumatic pregnancy, traumatic birth, incubator, frequent hospitalizations, holidays taken without you, etc.):

Would you describe your childhood as: **stable and nourishing** or **traumatic and stressful**? (please circle)

Circle how you consider your ability to cope with stress? (1 = poorly; 10 = excellently) 1 2 3 4 5 6 7 8 9 10

What methods do you use to cope with stress?

Do you have a history of recurrent colds or infections? (Strep throat, ear infections, sinusitis, tonsillectomy, etc.)

If applicable, are you approaching or undergoing menopause?

If so, when did your symptoms first become noticeable?

And how did the symptoms manifest?

Do you have any allergies? (medications, food, chemicals, inhalants) Please list:

Do you have any dietary restrictions? Please describe:

How long have you been following this diet?

What are your diet preferences?

Do you have food cravings? **Yes / No** ; Please specify:

Do you drink: Coffee (cups/day); Tea (green or black) (cups/day); Energy drinks (/day)

When was the last time you consumed a caffeinated beverage? (hours)

If you drink alcoholic beverages, what is your preference? Wine/Beer/Spirits

On average, how many alcoholic drinks do you consume per week?

Do you smoke? **Yes / No** ; If yes, on average how many cigarettes do you smoke per week?

Do you use recreational drugs? **Yes / No** ; Please specify type and frequency:

Do you exercise? **Yes / No** ; If yes, how often? (days per week)

What physical activities do you participate in?

Do you have any recreational hobbies? **Yes / No** ; Please list:

How frequently do you socialize with peers? With family?

On average, how many hours do you spend watching TV per day?

On average, how many hours do you spend in front of a computer/telephone/tablet per day?