Family Holistic Health Care of Fairfield
Neurobiofeedback Services

Laura R. Koch OT/L, BCN • 1100 Kings Highway East • Fairfield, CT 06825 Suite 1C • 203 576-1993

Neurointegration Intake Form

Name: _____

D.O.B.: ___/___/___ Gender: □Male □Female

Street Address: _____

Town, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Occupation: _____

Referred by: _____

Emergency Contact Name: _____

Relationship: _____ Phone #: _____

Diagnosis/Reason for Referral: _____

What symptoms would you like addressed through Neurointegration Training? _____

_____

_____

_____

Please answer the following questions to the best of your ability.

1. **Overall Health**

On a scale of 1-10, how would you rate your current health? 1 2 3 4 5 6 7 8 9 10
(1 being the worst, 5 being average, 10 being the best)

2. **Sleep**

Rate the quality of sleep you usually get in the past month. 1 2 3 4 5 6 7 8 9 10
At what time do you usually go to bed? _____am/pm
At what time do you usually rise for the day? _____am/pm
Are you able to sleep through the night? Yes No
If NO, please describe: _____

_____

Are you able to fall asleep easily most nights? Yes No
If NO, please describe: _____

_____

Do you wake refreshed? Yes No
If YES, please describe any exceptions: _____

_____

3. **Head or Neck Injury**

Have you ever injured your head or neck? Yes No
Have you ever had a concussion? Yes No
If YES, have you suffered from more than one concussion? Yes No
Have you ever been in a car, motorcycle, or bike accident? Yes No
Have you ever had a traumatic brain injury? Yes No
Are you currently receiving care for this/these injuries? Yes No
Please describe your head or neck injury(ies). Consider childhood, teen, and adulthood (if applicable), including home life, sports, accidents, slips/falls, etc. (use back if necessary): _____

_____

_____

4. Attention and Learning

Do you have a history of learning difficulties?	Yes	No
Do you have a history of ADD/ADHD?	Yes	No
Do you have a history of memory problems?	Yes	No

5. Moods & Emotions

Do you feel depressed or anxious in general?	Yes	No
Have you suffered from depression or anxiety in the past?	Yes	No
Have you been diagnosed with Obsessive Compulsive Disorder (OCD)?	Yes	No
Have you ever experienced panic attacks?	Yes	No
Do you have any history of psychiatric conditions in yourself such as schizophrenia, bi-polar disorder, or psychosis?	Yes	No
Is there a family history of psychiatric conditions such as schizophrenia, bi-polar disorder, or psychosis?	Yes	No
Have you ever contemplated suicide?	Yes	No

How would you describe your general emotional state? (A brief sentence or short phrase is fine.)

_____

_____

_____

6. Substances

Do you <u>currently</u> use psychoactive drugs, medications, or alcohol to pick yourself up or calm yourself down?	Yes	No	
Have you ever used psychoactive drugs, medications, or alcohol <u>in the past</u> to pick yourself up or calm yourself down?	Yes	No	
Are you currently a smoker?	Yes	No	
Do you consider your current use of tobacco, alcohol, or street drugs a problem?	Yes	No	N/A

7. Hormones

Are you concerned that hormonal imbalances may be contributing to your condition?	Yes	No

8. Counseling & Psychotherapy

Are you currently working with a psychiatrist, social worker, therapist, counselor, or clergy in matters regarding your mental health?	Yes	No

9. Medications, Supplements & Vitamins (use back if necessary)

Name	Dosage/Frequency	Symptom

10. Allergies

List any medication, food, and/or environmental allergies. _____

_____

_____

11. Light Sensitivity

Are you or have you ever had sensitivity to lights or strobe lights? Yes No

12. Other Health Issues

☐ Autism
☐ Chronic Fatigue
☐ Diabetes
☐ Fibromyalgia
☐ Headache/Migraine
☐ High Blood Pressure
☐ Parkinson's
☐ Other (Please describe)

☐ PMS
☐ Seizure Disorder
☐ Stroke
☐ Teeth Grinding
☐ Thyroid Problem
☐ Tinnitus (Ringing in Ears)
☐ TMJ

_____

_____

FAMILY HOLISTIC HEALTHCARE AND NEUROBIOFEEDBACK SERVICES

Douglas J. Koch, D.C., CCN, FIAMA
1100 Kings Highway East, Fairfield, CT 06825
www.FamilyHolisticHealth.com

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203 576-1993
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INFORMED CONSENT FOR NEUROFEEDBACK

Our practice offers neurofeedback therapy, also known as EEG biofeedback training, to clients requesting such services. The training is offered to children and adults, either self-referred or identified by parents, physicians, teachers, or other referral sources as having conditions shown to be responsive to this training. These conditions are generally thought to be those that appear to be associated with irregular brain activity where there is also clinical and research evidence to suggest neurofeedback training as a viable treatment approach.

Our staff has education, training, and experience in neurofeedback and in EEG technology, in addition to related professional disciplines such as psychology, rehabilitation, special education, and holistic medicine. We recommend the training on the basis of our education and our observations of improvement in clients with similar conditions. Scientific investigation is ongoing to determine the mechanism by which these improvements are achieved and therefore neurofeedback is considered by many to be an experimental treatment at this time. We use standard methods to determine the proper brain training program and to measure progress during and after brain training.

Neurofeedback Training has been the subject of more than 30 years of research and clinic study. The training appears to be harmless when conducted by a trained professional. Neurofeedback does not do anything to your or your child's brain. It is not a treatment; it is a training process. It offers information to the brain about its own activity, which your brain will use – or not – to adjust itself. It provides information to your brain which it can use to release its points of inflexibility and organize itself. The instruments are merely measuring devices similar to a thermometer. Sensors are placed on the surface of the head and you (or your child) is given information about what is being measured, via audio visual feedback. Your brain has the option to accept or reject the feedback, similar to one making a choice on whether to wear a coat, based on what temperature the thermometer reads.

As with many interventions, we cannot predict your personal response; some people experience dramatic shift and growth while others are slower in how they change. It is possible that you will perceive little or no change. It is possible that you experience some temporary unwanted effects in response to training. These may include fatigue, irritability, difficulty sleeping or a mild headache. Unwanted effects usually seem related to the instabilities that brought you into training in the first place. Our goal is to keep you as comfortable as possible, although this is not actually necessary for effective training to occur (e.g. Feeling sore after going to the gym does not mean you are not benefitting). The most important thing you can do to minimize unwanted effects is to let us know how you are feeling during and after training sessions. We can make changes in the training in order to help your process be as comfortable as possible.

If you, or your child, are subject to any form of seizures, epilepsy or visual photosensitivity please notify us prior to starting Neurofeedback training.

□ **I have read and understand the above neurofeedback description.**

Client Printed Name:_____

Client/Parent Signature:_____

Relationship if completed for minor:_____

Family Holistic Health Care

1100 Kings Highway East

Fairfield, CT 06825

203 576-1993

In order that we can send you statements, visit summaries (if requested), and other correspondences such as visit reminders, please provide us with your email address and cell phone information.

Email Address: _____

Cell Phone Number: _____

Cell Phone Carrier:

ATT _____ Verizon _____

Sprint _____ T Mobile _____

Cingular _____ Boost _____

Metro _____ US Cell _____

Virgin _____

I would like to receive appointment reminders via:

Email _____

Text _____

Email and Text _____

Print Name: _____

Signature: _____

Date: _____

FAMILY HOLISTIC HEALTH CARE AND NEUROBIOFEEDBACK SERVICES
1100 Kings Highway East Suite 1C
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PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent (see binder on Waiting Room book rack). The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also for the practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following: that appointment reminders will be used by the Practice. A separate form will be used to allow me to choose email and/or text notifications. I have the option to deny either or both.
4. The Practice may use/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary, for the Practice to conduct its specific health care operations.
5. I understand that the Practice may want to use my PHI to communicate with the CCA (Connecticut Chiropractic Association) to receive their assistance if necessary to resolve a dispute with an insurance company when a claim is denied or reduced. It has been explained to me that I can restrict the use of my PHI now or at a later date for the above expressed purposes.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to what the Practice has already taken action on in reliance on this consent.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (Printed) Signature of Individual

Date Signed _____/_____/_____

*If patient is a minor or unable to consent, parent/guardian/health proxy should complete below.

_____ _____

Signature of Legal Representative Relationship

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Financial Agreement

I have reviewed and understand the financial breakdown of the neurofeedback process:

Initial QEEG (brain map) - $450 Initial _____

Individual session pricing (if not paying package rate) - $150 Initial _____

Package pricing (includes 20 sessions and follow up QEEG, paid up front) - $2250
(Note: Package pricing is a financial grouping, not a clinical recommendation)
Initial _____

All payments are due on day of service and are accepted in cash, check, or credit card.

I understand and agree to payment as specified above. I also understand and agree that insurance and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Family Holistic Healthcare will prepare necessary forms to assist me in making collection from the insurance company. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of service.

_____ _____

Signature Date

_____

Printed Name