Intake Form

Field	
Name:	
Address:	
Phone:	
Email:	
Age:	
Emergency Contact:	
Occupation:	
Source of Referral:	
Main Reason for Coming In:	
Reason 1 (1-10):	
Reason 2 (1-10):	
Reason 3 (1-10):	

Current Medications

CDN does not interact with any medication

CDN asks all clients not to change their medications immediately before or during the course of their sessions. We want to only change one variable at a time — when more than one variable is changed, it is impossible to tell what is causing each effect. Only your physician should consult on changing your medications. Please inform your CDN practitioner if your current medications change in any way.

Relevant History

Has anyone else had Direct Neural Feedback in your family? Was the outcome successful?

Have you ever had a TBI/head injury, migraine or seizure?

Do you use alcohol, marijuana, or any other substances? How often?

Are you currently trying to quit or reduce your use of a substance (including cigarettes)?

Are you currently on a special diet or exercise program?

Sensitivity

Do you consider yourself sensitive to sound, light, or smell?

Are you often overwhelmed by sensory stimuli?

Estimate your sensitivity to medications—do you take high, low or average dosages?