BRAINCODECORP
Developing Your Mental Game

NeuroSport™
KNOW YOUR BRAIN AND GET IN THE GAME!

CLIENT INTAKE FORM

CLIENT NAME: _____ _____ PHONE NO: _____

EMAIL: _____ DATE OF BIRTH: _____ AGE: _____

ADDRESS:
_____

Effective evaluation begins with a wholistic, accurate, and honest information. This form is crucial in providing the best information to assist you in moving forward. Please answer the following questions as completely as possible. Feel free to write on the back as necessary.

Please state your primary reason for seeking an assessment or services at this time.

What are the areas of your life you believe you are NOT performing your best? How come?

What are the 3 primary goals and objectives you are striving to achieve right now?

1.

2.

3.

What would you like to achieve long term 1-5 years?

Please state specifically what you are willing to do to reach these goals/outcomes:

Please tell me about what makes you happy.

What are you unhappiest about in life right now?

Please state any obstacles, challenges, or limitations you see in reaching your goals mentioned:

What major stressors or challenges do you face right now?

What painful events or losses have recently occurred?

Braincode Corp/NeuroSport
Anne "Kip" Rodgers Watson, MA, LPC-S, CHPC
Email: kip@braincodecorp.com

What have you done to address these problems and stress? What has worked or not worked?

Describe how you react after making a mistake or getting stuck in a rut or slump?

What are examples of *automatic negative thoughts* holding you back from achieving your goals?

Please describe in detail the symptoms you have experienced and when do you estimate these symptoms began:

What has been the course of your symptoms? (*circle one*):
Very good Good Average Poor Improving Declining

When have you experienced similar symptoms? If so, when?

What made the symptoms better? What made the symptoms worse?

Please circle your answer and describe any *Yes* answers to the questions below.

Consistently down or depressed mood most of the day, nearly every day? Yes/No

Diminished level of interest or pleasure in most or all activities? Yes/No

Change in appetite? Yes/No Change in weight? Yes/No

Change in sleep pattern? Yes/No Change in sex drive? Yes/No

Feeling agitated or slowed down? Yes/No Fatigue or loss of energy? Yes/No

Difficulty thinking or concentrating? Yes/No Irritability, rage, or violent behavior? Yes/No

Feelings of worthlessness or excessive guilt? Yes/No

Attacks of hyperventilation, palpitations, or intense fear? Yes/No

Change in drinking/drug use pattern? Yes/No

Thoughts of death or suicide (or any attempts)? Yes/No
If yes, how would you

Have you ever planned or made a suicide attempt? Yes/No
Please describe:

What phobias or unusual fears do you have?

Have you ever experienced auditory or visual hallucinations? Yes/No
Please explain:

Do you have access to any firearm (handgun, rifle, shotgun, etc.)? Yes/No

Braincode Corp/NeuroSport
Anne "Kip" Rodgers Watson, MA, LPC-S, CHPC
Email: kip@braincodecorp.com

Psychiatric/Counseling History:
Any prior therapy, psychiatric care, or hospitalization? Yes/No *(circle one)*

Explain what DID or DID NOT work about your previous counseling/treatment experience:

Please list all the psychiatric medications (for depression, anxiety, insomnia, etc.) you have ever taken. Please describe any benefits or side effects that you experienced:

Medication(s) **Benefits/Side Effects:**

Current Medication/Supplements: (list all prescription and over-the-counter medicines)

1. _____ Purpose: _____
2. _____ Purpose: _____
3. _____ Purpose: _____
4. _____ Purpose: _____

GENERAL PHYSICAL HEALTH:

Rate your physical health: (*circle one*)
Very Good Good Average Poor Improving Declining

Have you taken the full vaccine schedule? Yes/No Have you taken the Covid Vaccine? Yes/No

Current Approximate Weight: _____ Height: _____
Weight Changes recently: Lost_____(lbs) Gained_____(lbs)
Last Physical Exam: _____

For Men & Women: Have you ever terminated a pregnancy? Yes/No Miscarriage? Yes/No

For Women only: Are you current with gynecological exams: Yes/No
Regular periods: Yes/No Painful periods: Yes/No

List all concussions, blows to the head, illnesses, allergies, injuries, loss of consciousness, or handicaps? Any recent MRI, X-ray, or spect scans performed? Surgeries or hospitalizations?

DAILY HEALTH PRACTICES:

Number of hours of sleep per night: ____ Number of glasses of water per day: _____
Number of meals per day: ____
Typical breakfast: Typical lunch:
Typical dinner: Typical snack foods:

Do you meditate? Yes/No
How often do you read or seek personal development time?
Daily Exercise: Yes/No Weekly Exercise: Yes/No
Types of Exercise you enjoy: Types of Exercise you hate:

Highest Weight at Current height: Lowest Weight at Current height:

Any history of food binging: Yes/No If yes, how often?

Braincode Corp/NeuroSport
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Email: kip@braincodecorp.com

Any history of food restriction: Yes/No If no, how long without food?

Any use of laxatives, diuretics, diet pills, detox/cleanses? Please circle and describe:

For Women: Ever experienced the absence of three or more periods other than during pregnancy?

Family History:
Please take the time to think of your various blood related kin. Please note if any had problems (even if no treatment was received) with the following: anxiety, depression, bi-polar, eating disorders, phobias, suicidal behavior, drug or alcohol dependency, schizophrenia, or Alzheimer's disease. Please note any other psychiatric issues.

RELATIVE **PROBLEM/SYMPTOMS**

Any family medical history of other types of diseases or conditions (i.e., diabetes, cancer, heart conditions): Yes/No

RELATIVE **DISEASE/CONDITION**

SUBSTANCE USE/HISTORY:

Nicotine: Yes/No
Packs/Vape per day:
Years of smoking:

Caffeine: Yes/No
What is your daily intake of coffee, tea, cola drinks or caffeine pills?

Alcohol: Yes/No
Average daily consumption:
Highest intake in 24-hours:
Age of first drink:
Age at first intoxication:
When was your last drink:

Has drinking had a negative effect? Example: hungover, accidents, legal (DWI, PI), health, job/school, marital, financial, emotional, reputation, or other problems?(*circle all that apply*)

Use scale to rate your use of alcohol: 0 ---------- 10

No Problem **Definite Problem**

Other Drugs: Yes/No
Marijuana, cocaine, amphetamines, LSD, heroin (or other IV drugs), mushrooms, ecstasy, inhalants, prescription narcotics or other substances. *Please circle and describe:*

Age of first illegal drug:
Last use of any illegal drug:

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Email: kip@braincodecorp.com

Longest time without drugs?
Have you ever used any drug **not** prescribed by a doctor? Yes/No (*circle one*)
Have you experienced an overdose or side effects due to your drug use? Yes/No (*circle one*) If yes, please explain:

Use scale to rate your use of drugs: 0 ---------- 10

No Problem Definite Problem

TRAUMA/ABUSE HISTORY:

Please describe if you have experienced any of the following:

Intrusive thoughts of traumatic events:
Recurrent nightmares:
Flashbacks of frightening events:
Avoidance of situations or people:

Physical Abuse includes face slapping, shaking a child, hair pulling, head banging, lack of appropriate physical nurturing, intrusive procedures, and hitting with an object.

Have you ever been physically abused: Yes/No (*circle one*) What happened?

Sexual Abuse includes *physical-sexual abuse* (any form of **non-consenting** sexual activity with an adult and in childhood, or adult over-powering and/or manipulating another adult or adolescent: sexual intercourse, rape, oral sex, anal sex, masturbation of a child/adolescent, having a child/adolescent masturbate an adult, sexual touching/fondling, sexual kissing, sex witnessing), *covert-sexual abuse* (when a parent or caregiver does not set appropriate sexual boundaries with a child or when a child witnesses sexual abuse).

Have you ever been sexually abused? Yes/No (*circle one*) What happened?

Emotional Abuse is when a parent, caregiver, or significant other refuses to allow you as a child or an adult to express your feelings, shames you for your feelings or demonstrates improper expression of his/her feelings in front of you. It also includes a parent, caregiver, or significant other being disrespectful of your feelings, opinions, or thoughts, and/or demanding perfection, over-controlling, ignoring, neglecting, abandoning, or indulging you.

Have you ever been emotionally abused: Yes/No (*circle one*) What happened?

Mental Abuse includes a parent, caregiver, or significant other attacking and belittling your thinking process when you were a child or as an adult. It is over-control of the expression of a thought and failure on the part of a parent or caregiver to teach logical thinking and problem solving.

Have you ever been mentally abused: Yes/No (*circle one*) What happened?

Spiritual Abuse includes a parent, caregiver, or significant other that denies your free will to believe in a spiritual path you desire. It occurs when there is over-control in following a certain spiritual path. Spiritual abuse also occurs when a parent or caregiver does not follow the established family rules or values as though he/she is above those rules and values.

Have you ever been spiritually abused: Yes/No (*circle one*) What happened?

Financial Abuse is when a parent, major caregiver, friend, or authority figure takes advantage of you for financial gain. It can be repeated patterns of borrowing money with no return, taking money without asking, and patterns of using your money to keep them out of trouble.

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Email: kip@braincodecorp.com

Have you ever been financially abused: Yes/No (*circle one*) What happened?

Other types of abuse include peer or social abuse for reasons of race, religion, sexuality, and/or physical appearance.
Have you ever experienced any of the above: Yes/No (*circle one*) What happened?

If you have trauma/abuse history, how much of the details have you processed in treatment?

To whom have you disclosed these experiences? What was their response?

OCD:
Experience persistent obsessive thoughts or images of contamination or lack of safety?

Experience persistent compulsive behaviors, cleaning, washing, checking, counting, tapping, touching, repeating, or arranging, ordering? *(Circle any that apply)*

FAMILY BACKGROUND:

Current city/town: Length of time in local area:
Place of Birth: Raised in Rural/Suburban/Urban/Overseas? (*circle one*)
Primarily raised by:

Describe what your early years growing up were like in your family:
Describe what your teenage years were like in your family:

Who did you feel close to growing up? Why?

Father's Name:
Number of Years of School:
Current age/age at Death:
Occupation:

Mother's Name:
Number of Years of School:
Current age/age at Death:
Occupation

Describe Father's Personality/strengths/weaknesses:
Describe Mother's Personality/strengths/weaknesses:
Describe your parent's relationship:

What were/are the most important family values? What is the family 'motto'?

Any stepparent figures in your life? Y/N (*circle one*) If yes, please list who and the effect or impact on your life:

Write the names and ages of each sibling in descending order beginning w/ the oldest. Include any deceased siblings. Use the back of the page if there are more than four siblings in your family.

Sibling #1
Name:
Current age or age at death:
Cause of death:
Describe your relationship:

Sibling #2
Name:
Current age or age at death:
Cause of death:
Describe your relationship:

Braincode Corp/NeuroSport
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Email: kip@braincodecorp.com

Sibling #3
Name:
Current age or age at death:
Cause of death:
Describe your relationship:

Sibling #4
Name:
Current age or age at death:
Cause of death:
Describe your relationship:

Are any of your siblings/stepsiblings adopted: Yes/No (*circle one*) If yes, who?

CURRENT RELATIONSHIP:

Status (*circle one*):
Married (Years ____) Separated Divorced Widowed Single Engaged Single in a Relationship

Quality of present relationship: Poor/Fair/Good/Excellent (*circle one*)

Previous Marriage(s): First (Duration___) Second (Duration___) Third (Duration___)

What are typical arguments or conflicts focused on?

How often do you argue or get into conflict? How easily resolved?

How did you meet your current relationship? What attracted you to him/her?

Current number of close friends:

Children:

Name Birth Date Gender Relationship at Home?

DATING AND SEXUAL HISTORY:

Age of first date:
Age when you became sexually active:
Parents thoughts on dating at this age:
Parents thoughts on you being sexually active:

Please check any of the following you have experienced:

____Exhibitionism/indecent exposure/flashing
____Adultery (extramarital affair(s))
____Sadism (inflicting pain on partner)
____Rape/statutory rape or date rape
____Molesting
____Pornography (photos, video, literature, internet)
____Masturbation
____Sex Repression
____Group sex or polyamory
____Unable to reach climax or orgasm
____Abortion
____Incest (sexual contact w/ relatives)
____Masochism (want partner to inflict pain)
____Homosexuality
____Prostitution
____Menopause
____Impotence
____Premature ejaculation or orgasm
____Wish to speak privately on this subject

Braincode Corp/NeuroSport
Anne "Kip" Rodgers Watson, MA, LPC-S, CHPC
Email: kip@braincodecorp.com

Sexual partner history:
____number of female partners ____percentage of safe sex practiced

____number of male partners ____percentage of safe sex practiced

EDUCATION:

Highest Level of Education: Major:
Institution/University: Degree(s):
Vocational Training: Yes/No What skills?

Learning disorder? Yes/No If yes, what?
Special education classes? Yes/No
Diagnosed with ADD/ADHD? (*circle one*) School was easy/difficult
I liked studying: I hated studying:

WORK:

Current Occupation: Length of employment:
Past Occupation: Length of employment:

Describe satisfaction with current work situation: (*circle one*)
Very good Good Average Poor Improving Declining

Average hours per week: Number of jobs in last 3 years:
Longest time at the same job (*in years*):
Has your income *increased/decreased/stayed the same* in the last two years? (*circle one*)

Military:

Have you served in the military: No/Volunteered/Drafted (*circle one*)
Length of service in years: Branch: Rank:
Combat Experience: None/Minimal/Moderate/Heavy (*circle one*)
Discharge Status: Dishonorable/Honorable/Standard/other (*circle one*)

FINANCIAL:

Describe current financial situation: (circle one)
Very good Good Average Poor Improving Declining

Do you gamble? Y/N (*circle one*) If yes, how often? Largest loss:
Who contributes income to your household unit? Estimated Total Debt:

LEGAL:

Describe current/past legal problems?
Number of times ever arrested Number of times charged: Number of convictions:
Age of first arrest: Age of last arrest:

Have you had any legal problems in the **past two years**: *(please describe)*
Are you currently involved in any legal situations? *(please describe)*

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Email: kip@braincodecorp.com

SPIRITUAL BACKGROUND:

Religious/Spiritual/Denominational Preference:

Church Member: Yes/No Church currently attend: Attendance/month?

Explain spiritual or religious upbringing? Do you hold to that upbringing?

SELF EVALUATION: Rate your performance in the following areas: **0 - very poor to 10 - excellent**

____Physical Health/Fitness	____Financial	____Emotional
____Social	____Spiritual	____Legal
____Job	____School	____Self-Worth
____Family	____Leisure Time/Hobby	____Mental

FINAL THINGS:

What are your finest attributes? Greatest achievements/accomplishments?

Greatest failure? Greatest disappointments/regrets?

How do you express sadness or grief? How do you express resentment or anger?

How often do you write down or journal your private thoughts and feelings?

When do you have fear/doubt/lack confidence?

ACTIVITIES AND INTERESTS:

List clubs or organizations/special talents/hobbies you belong to or do:

List any awards received:

Are you on social media sites? Yes/No (*circle one*) If so, which ones?

How much time do you spend on these social/internet sites per day?

What is the household phone policy?

Do you have TV/electronics in your bedroom? Yes/No (*circle one*)

Favorite color: _____ Favorite vacation spot: _____
Favorite movie: _____ Favorite meal: _____
Favorite restaurant: _____ Favorite TV show: _____
Favorite website: _____ Favorite music artists/groups: _____

Describe your 'perfect' day:

Anything else you want to say you have not said?

Congratulations! You made it through this long questionnaire. Thank you for your honest answers. We understand this is very personal in nature. It assists in understanding you and providing you with the best possible plan to help you achieve your goals.

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