

Virginia Neurofeedback, Attachment & Trauma Center

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(434)960-2519

Contact Information

Name: _____ Date of Birth: _____

Address: _____ SSN#: _____

_____ Main Phone: _____

Email: _____ Other Phone: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Medical & Psychological History

Primary Care Physician: _____ Phone: _____

Your reason for consultation right now?

Please list chronic illnesses or health conditions you have had or have currently:

How were you before these problems occurred (if relevant)?

Current medications (prescription or over-the-counter), reasons for taking them, and their effects on you?

Are you currently being treated for an emotional or medical condition? Please describe if so.

Have you ever had therapy, counseling or neurofeedback before? Yes ___ No ___ If yes:

| <u>Dates of treatment</u> | <u>Therapist Name</u> | <u>Effective?</u> |
|---------------------------|-----------------------|-------------------|
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Please list significant illnesses in your family (for example; diabetes, cancer, head injury, heart problems, surgeries, emotional/psychiatric history, or substance abuse):

What do you do to maintain your health? List any supplements or herbs you may take.

If you feel pain in your body, please mark where (indicate front or back of body) and describe the sensation:

