Doric George M.A.

Board Certified Professional Counselor
Licensed Professional Clinical Counselor #LPC208
Licensed Marriage & Family Therapist #MFC38343
Certified Othmer Neuro Feedback Therapist

CONFIDENTIAL QUESTIONNAIRE

Please print out this form and fill it in as completely as you can in your own handwriting.

How did you hear about us? ______________________________ May we thank them? ____________

Name: ____

Address: ____

____

Tel. Home: _________________ Work: __________________ Cell: _____________________

Email: ______________________ Date of Birth: _____________ Age: _____ Sex: ______

What's the best way to reach you:____

Primary Parent/Custodian: ____________________________ Relationship: _______________________

Address:____ Phone: _______________________

Other Parent/Custodian: ______________________________ Relationship: _______________________

Address:____ Phone: _______________________

Siblings? ______ Names & ages: ____

Grade Level: ___________________Work Experience: _______________________________________

School Name: ____

Interests, sports, activities:____

Have you ever had EEG Therapy? ________________ Results? ________________________________

____

Do you know anyone else who has? _______ Results? ____

____

Have you ever been in therapy (briefly describe)? ____

____

310.717.1771

11600 Washington Place, Suite 208 — Culver City, CA 90066

What are your primary reasons for seeking help at this time? What would you like to achieve? What do you expect from treatment? (say as much or as little as you like, parental input is encouraged)

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Medical Information

Are you currently under the care of a physician? ___ Yes ___ No

(If yes, please explain)____________________

Do you have any medical conditions (Heart problems, blood pressure, diabetes, etc)? ___ Yes ___ No

(Please list) ____________________

Are you currently taking any medications? ___ Yes ___ No

(Please list) ____________________

Have you ever taken any psychiatric medications (for depression, anxiety, Bi-Polar, Schizophrenia, etc.)
Or have you ever been hospitalized for mental/emotional reasons? ___ Yes ___ No

(Please Explain)____________________

Ever had severe depression, panic attacks, or seriously considered suicide? ___ Yes ___ No

(Please Explain)____________________

Do you ever drink alcohol or use marijuana or other “Recreational” drugs? ____________________

(What & how often?)____________________

Do you have any type of epilepsy? ___ Yes ___ No

Have you recently seen a physician or health professional? ___ Yes ___ No

List all diagnoses, please: ____________________

____

Are you taking any dietary supplements? ___ Yes ___ No

Please list them:____________________

Do you have any dietary restrictions or special diets? ___ Yes ___ No

Please describe: ____________________

Did a physician or health professional recommend that you try Neuro Feedback? ___ Yes ___ No

The above information I have provided herein is true and complete to the best of my knowledge and I have revealed all medical and psychological information that might effect my participation in this program. Complete professional confidentiality will always be maintained including the content and the fact of our therapy sessions except under certain circumstances as mandated or allowed by law, such as the presence of a reasonable suspicion of child abuse or a serious danger to client or others.

Name Printed: ____________________ City/State ____________________

Signature: ____________________ Date: ____________________

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