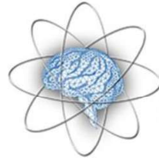


TBI Therapy Intake

Name ____ Date of Birth ___________________________

Phone number ___________________________ Email _______________________________________

Address ____

Relative to contact if unable to speak (name/relation/number) __________________________________

Who referred you/How did you hear about us? ____

Primary Physician ____

Chief Complaint

Describe what happened ____

____

How long ago did the injury occur? ____

How severe was the trauma?

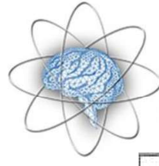
- ☐ Significant trauma (e.g. motor vehicle accident, blunt trauma to head, multiple concussions)
- ☐ Moderate trauma (e.g. fall from less than 8 feet, single sports concussion)
- ☐ Minor trauma or no trauma (e.g. whiplash, emotional trauma, chemical insult, drug side effect)
- ☐ No trauma

Did you receive emergency medical care?

- ☐ Went to the ER
- ☐ Stayed overnight at hospital
- ☐ Surgery was performed
- ☐ No emergency medical care was required

What were your **initial** symptoms? (select all that apply)

☐ Headache	☐ Sensitivity to light	☐ "Don't feel right"
☐ Head Pressure	☐ Sensitivity to sound	☐ Difficulty concentrating
☐ Neck Pain	☐ Craving sweets	☐ Difficulty remembering
☐ Nausea or vomiting	☐ Loss of appetite	☐ Sleep issues
☐ Dizziness	☐ Decreased libido	☐ Oversleeping
☐ Blurred Vision	☐ Feeling slowed down	☐ Fatigue or low energy
☐ Balance Problems	☐ Feeling like "in a fog"	☐ Confusion



- ☐ More emotional
- ☐ Depression
- ☐ Irritability
- ☐ Sadness
- ☐ Nervous or anxious
- ☐ Shame or guilt
- ☐ Easily distracted
- ☐ Difficult making decisions
- ☐ Difficult communicating thoughts or feelings
- ☐ Difficult taking care of yourself

What treatments have been performed? Any improvements since?

____

What are your **current** symptoms? (select all that apply)

- ☐ Headache
- ☐ Head Pressure
- ☐ Neck Pain
- ☐ Nausea or vomiting
- ☐ Dizziness
- ☐ Blurred Vision
- ☐ Balance Problems
- ☐ Sensitivity to light
- ☐ Sensitivity to sound
- ☐ Craving sweets
- ☐ Loss of appetite
- ☐ Decreased libido
- ☐ Feeling slowed down
- ☐ Feeling like "in a fog"
- ☐ "Don't feel right"
- ☐ Difficulty concentrating
- ☐ Difficulty remembering
- ☐ Sleep issues
- ☐ Oversleeping
- ☐ Fatigue or low energy
- ☐ Confusion
- ☐ More emotional
- ☐ Depression
- ☐ Irritability
- ☐ Sadness
- ☐ Nervous or anxious
- ☐ Shame or guilt
- ☐ Easily distracted
- ☐ Difficult making decisions
- ☐ Difficult communicating thoughts or feelings
- ☐ Difficult taking care of yourself

Any other symptoms? ____

How is your mobility?

- ☐ Wheelchair required
- ☐ Require assistance walking
- ☐ No assistance needed

Are you able to eat on your own?

- ☐ Yes, I eat independently
- ☐ No, I require assistance
- ☐ No, I have a feeding tube

Are you able to verbally communicate?

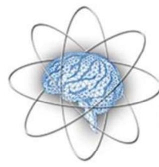
- ☐ Yes, I can speak well
- ☐ Yes, but speaking is difficult
- ☐ I rely on written communication
- ☐ No, I cannot speak or write and I require assistance

Mental Health Conditions:

- ☐ No mental health history
- ☐ Mental health conditions in family history
- ☐ Personal mental health disorder
- ☐ Seeing a psychiatrist

Do you have a mental health diagnosis (e.g. depression, anxiety, bipolar disorder, schizophrenia)?

____



TBI Therapy
Regenerative Therapy for Brain Injury

Medical / Social

List medications and supplements currently taking ____

____

Do you have any other medical conditions? ____

____

Family medical history ____

Allergies ____

Alcohol / Tobacco / Drugs (if so, how much?) ____

Diet (typical breakfast, lunch, dinner, snacks) ____

Social (occupation, who you live with) ____

Exercise (how much and what type) ____

Chemical Exposures (if so, what substance) ____

Spiritual (how do you care for your spiritual essence) ____

Review of Systems

Head: Headaches, or migraines?

____

Ears: Ringing or discharge?

____

Eyes: Blurry, floats, trouble seeing at night?

____

Mouth: Root canals or amalgams?

____

Neck: Trouble swallowing, masses, stiff?

____

Chest: Chest pain, palpitations, murmurs?

____

GI: Stomach pain, burning? Bowel movements?

____

GU: Urinary urgency, incontinence, painful?

____

MS: Movement of head, neck, torso, arms, hips, legs, or feet?

____

Skin/Hair/Nails: Hair loss? Rash? Cracked nails?

____

Neuro: Sensation changes in arms and hands?

____

Psyche: Frequent mood changes?

____

Health Maintenance: Vaccinations?

____