Preferred Client Information

Name: (Mr./Mrs./Ms.) circle one **Date:**___/___/_____

Last:_______________________________ ***First***:____________________________________

Birth Date: ___/___/______ ***Current Age:***____ ***Profession:*** _________________________

Married / Partnered / Single / Divorced / Widowed *Number of Children* __________

Contact Information:

Telephone: Work:___________________ Home:_____________________________

Email:________________________________ Cell:______________________________

Can we send appointment reminders to your cell via text? (Yes / No)
Provider_________________
(ex: Sprint, AT&T, etc.)

Address:

Line1:____

City:_________________________ State: ______ Zip:_______________

Emergency Contact:

Name:__________________________ Relation: _________Phone:___________

Were you referred to us by someone? (Y / N) circle one

If yes, by whom? ____
If no, how did you hear about us? _______________________________________

What is your chief complaint? ____

What are your other major complaints? ____

Have you ever had: a seizure? (Y / N) a stroke or brain bleed? (Y / N) a major head injury? (Y / N)

Do you have any children / nieces / nephews / grandchildren with health challenges (mental / emotional / physical)? ____________________

TRACKING YOUR PROGRESS

Fill this out in combination with the checklist of concerns before you start training and then every ten sessions.

NAME: ______________________________ DATE: ______________

SESSION (CIRCLE) 1 10 20 30 40

Medication I am on (how much, how often): ______________________________

CONCERN Pick the concerns you circled that you would like to change the most. Add any other concerns you want to track	FREQUENCY How many times did you feel this way in the past week, or how many days out of 7?	INTENSITY How strong was it 0-10	DURATION How long did it last? Do not count when you were sleeping
1.			
2.			
3.			
4.			
5.			

SETTING YOUR GOALS

Fill this out before you start your training with NeurOptimal®

I will know NeurOptimal® is working if….

1.
2.
3.

NeurOptimal® Neurofeedback

Headway Health

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Bldg. 15, Ste. 1504
Austin, Texas 78746
Phone: (512) 523-5711

I ____________________ understand that NeurOptimal® is not a medical treatment, device or methodology. It is not used to diagnose medical disorders nor is it used as a medical treatment for disorders and has not been approved for any medical purpose by the FDA, Health Canada or any other governing agency. While Zengar trainers may or may not be licensed health care practitioners, their use of NeurOptimal® is solely as a tool for brain training and optimization and not as a means of diagnosis or as a medical intervention.

I am satisfied with the information I have been provided (verbal, written or otherwise) by my trainer on the effects I can expect during my NeurOptimal® training and my questions have been answered to my satisfaction. I understand that it is not possible to predict what my central nervous system will do with the information it is offered and consequently there can be no guarantee as to the results of my training.

I agree to cease training if I am less than happy with the results I am getting. I understand NeurOptimal® is purely a source of information and does not direct the response of the central nervous system. Consequently I agree to not hold Zengar Institute Inc or any of its users and trainers responsible for a less than desired outcome or any outcome that may be considered negative.

Your Signature ____________________________________

Your Printed Name_________________________________

Parent or guardian signature (for clients under the age of 18)

____

Today's Date _______________

HIPPA

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that Headway "Notice of Privacy Policies" has been provided to me. I understand I have a right to review the "Notice of Privacy Policies" prior to signing this document. "The Notice of Privacy Policies" is also provided upon request.

Members of the staff may need to contact you with appointment reminders of information related to your treatment. If this contact is made by phone, and you are not at home, a message will be left on your answering machine or with whoever answers the phone. By signing this form you are giving us authorization to contact you with these reminders and information.

____________________________________ ____________________
Patient Name Printed Date

____
Patient Signature

48 Hour Cancellation Policy

We strive to make my office run as smoothly as possible and to help make your experience here as satisfying and pleasant as possible.

To do this, we allow plenty of time for your visit. Unlike many physicians' offices that schedule six to eight patients per hour to compensate for those who do not show up, we regularly see only one or two people per hour. In order for our office to run as smoothly as possible we ask that you give us ample notice if you cannot make your appointment.

Please note that we have a **48-hour** cancellation policy. Please bring your calendar in order to set up your follow-up appointments. If you need to reschedule your appointment at anytime during your series, please give us at least 48 hours notice so that your time slot can be used by other clients. If we do not receive at least 24 hours notice, you will be charged in full for your missed appointment. Naturally, we will make an exception to this in the event of genuine emergencies, such as acute illness or accidents. This policy is not intended to be punitive; it simply allows us to keep an appointment schedule that allows quality care for every client.

Please sign below to acknowledge that you have read my scheduling policy and that you accept these terms. Thank you for your understanding and compliance of this necessary policy.

Signature:___________________________________ Date:____________________