

**INSTITUTE FOR PERSONAL EXCELLENCE, P.A.**  
a Brain Fitness Center

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**NEW CLIENT QUESTIONNAIRE**

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Nickname: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
Sex: M F

**HEALTH PERCEPTION / HEALTH MANAGEMENT (Present Health Status):**

1. In general, please rate your overall health (please circle a number):  
0 1 2 3 4 5 6 7 8 9 10  
Unhealthy/ ill Very Healthy

2. Have you ever had any of the following:  
\_\_\_\_\_ Angina \_\_\_\_\_ Arrhythmia \_\_\_\_\_ Heart Attack  
\_\_\_\_\_ Other (please specify) \_\_\_\_\_

3. Blood pressure problems? Yes No  
If yes: For how many years \_\_\_\_\_  
Range of blood pressure \_\_\_\_\_  
Have you ever been treated with medication? Yes No  
Are you being treated now? Yes No

4a. List any prescribed medications and doses you are currently taking.  
NAME DOSE FREQUENCY  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. How often do you forget to take your medication?  
never occasionally once a day more than once a day

c. List any over-the-counter medications (including aspirin) or dietary supplements (i.e. vitamins / minerals) you are currently taking.  
NAME DOSE FREQUENCY  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

d. Have your medications ever caused you any unusual side-effects or problems? If so, please describe: \_\_\_\_\_  
\_\_\_\_\_

5. Do you have any drug / food allergies? Yes No  
If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

**PAST HEALTH STATUS**

1. Have you ever had any of the following:  
\_\_\_\_\_ Anemia \_\_\_\_\_ Phlebitis  
\_\_\_\_\_ Anxiety / Depression \_\_\_\_\_ Rheumatic Fever  
\_\_\_\_\_ Arthritis \_\_\_\_\_ Seizures  
\_\_\_\_\_ Asthma \_\_\_\_\_ Sleeping Disorders  
\_\_\_\_\_ Concussion \_\_\_\_\_ Stroke  
\_\_\_\_\_ Heart murmur \_\_\_\_\_ Thyroid Problems  
\_\_\_\_\_ Injuries to back, arms, legs \_\_\_\_\_ Broken Bones  
Other: \_\_\_\_\_  
\_\_\_\_\_

2. Do you have a primary care physician? Yes No  
Name and Address: \_\_\_\_\_  
\_\_\_\_\_ Telephone: \_\_\_\_\_

3a. Have you ever sought counseling? Yes No  
If yes, please indicate type of counselor: \_\_\_\_\_  
Please indicate when: \_\_\_\_\_

b. Are you currently in treatment with a \_\_\_ psychiatrist, \_\_\_ psychologist, \_\_\_ social worker, \_\_\_ therapist, or \_\_\_ other type of counselor? (Please check all that apply)  
If yes, how long in treatment? \_\_\_\_\_  
How often do you meet? \_\_\_\_\_

c. Have you found this support helpful? (Please circle a number)  
1 2 3 4 5  
Not at all Somewhat Very helpful

Name, address and telephone number of current counselor:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HEALTH HABITS**

1. Do you smoke cigarettes? Yes No
- If yes:
- a. How many packs a day? \_\_\_\_\_
  - b. For how many years? \_\_\_\_\_
  - c. Have you ever stopped smoking in the past? Yes No
  - d. How soon after you wake up do you smoke your first cigarette?  
 \_\_\_\_\_ within 30 min. \_\_\_\_\_ after 30 min.
  - e. Do you find it difficult to refrain from smoking in places where it is forbidden, such as in church, at the library, in the cinema, etc.?  
 Yes No
  - f. Which cigarette would you most hate to give up? \_\_\_\_\_
  - g. How many cigarettes per day do you smoke?  
 \_\_\_\_\_ 15 or less \_\_\_\_\_ 16-25 \_\_\_\_\_ 26 or more
  - h. Do you smoke more frequently during the first hours after awakening than during the rest of the day? Yes No
  - i. Do you smoke even if you are so ill that you are in bed most of the day? Yes No
  - j. What is the nicotine level of your usual cigarette brand?  
 \_\_\_\_\_ 0.9 mg or less \_\_\_\_\_ 1.0-1.2 mg \_\_\_\_\_ 1.3 mg or more
  - k. Do you inhale? \_\_\_\_\_ Never \_\_\_\_\_ Sometimes \_\_\_\_\_ Always

- If no: Did you ever smoke cigarettes? Yes No
- a. When was the date of your last cigarette? \_\_\_\_\_
  - b. Did you stop on your own? Yes No
  - c. Number of packs/day \_\_\_\_\_
  - d. For how many years? \_\_\_\_\_
  - e. Does anyone in your home smoke? Yes No  
 If yes, whom? \_\_\_\_\_

2. Do you drink alcohol? Yes No
- If yes: wine (glasses/wk) \_\_\_\_\_ beer (glasses/week) \_\_\_\_\_ alcohol (oz/wk) \_\_\_\_\_
- a. Have you ever felt you should cut down on your drinking? Yes No
  - b. Have people annoyed you by criticizing your drinking? Yes No
  - c. Have you ever felt bad or guilty about your drinking? Yes No
  - d. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hang-over (eye-opener)? Yes No

3. Do you use recreational drugs? Yes No
- \_\_\_\_\_ Pot \_\_\_\_\_ Cocaine \_\_\_\_\_ Other (please list) \_\_\_\_\_

**NUTRITION/METABOLIC**

- 1.a. Do you consider yourself: \_\_\_ overweight \_\_\_ underweight \_\_\_ about right?
- b. What is your ideal weight? \_\_\_\_\_ Has your weight changed recently? Yes No
- c. Have you ever been seen by a dietician for nutrition counseling? Yes No  
If yes, where? \_\_\_\_\_
  
- 2.a. Do you follow a special food plan? Yes No  
If so, is it \_\_\_ low sodium \_\_\_ low fat and cholesterol \_\_\_ low calorie  
\_\_\_ other (describe) \_\_\_\_\_
- b. How much of the time do you follow your food plan?  
\_\_\_ always \_\_\_ usually \_\_\_ about half the time \_\_\_ occasionally
  
- 3.a. Do any of the factors listed below make it difficult for your to eat right?  
\_\_\_ Eating out \_\_\_ frequent snacking \_\_\_ dislike recommended food  
\_\_\_ Moods \_\_\_ some one else cooks \_\_\_ taking large portions  
\_\_\_ Lack of information on healthful eating  
\_\_\_ Other (describe) \_\_\_\_\_
  
- 4.a. How many times per week do you usually eat out? \_\_\_\_\_
- b. Where? (restaurant, cafeteria, family/parent's home, friend's home, etc.)
  
5. Do you salt your food? Yes No
  
6. Do you drink caffeinated beverages? Yes No  
If yes, please indicate the number of cups per day of the following:  
\_\_\_ Coffee \_\_\_ Tea \_\_\_ Cola \_\_\_ Cocoa
  
7. Do you eat chocolate? Yes No  
If yes, please indicate the amount per day: \_\_\_\_\_
  
8. What foods do you usually choose for snacks? \_\_\_\_\_
  
9. Are there any foods that you try to avoid? Yes No  
If yes, what? \_\_\_\_\_
  
10. Are there any changes that you would like to make in your eating behaviors? \_\_\_\_\_  
\_\_\_\_\_

**ACTIVITY/EXERCISE**

1. How active are you? \_\_\_ Very \_\_\_ Moderately \_\_\_ Sedentary
2. Has this changed recently? Yes No  
If so, why? \_\_\_\_\_  
\_\_\_\_\_
  
3. Do you have any physical problems that limit your activity? Yes No

If yes, please describe: \_\_\_\_\_

4. If you currently exercise on a regular basis, please complete the following:

ACTIVITY (walking, biking, weights, etc.)	# SESSIONS/WEEK	MINUTES/SESSION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. What types of activity do you do around the house or in your leisure time (i.e., housework, Gardening, woodworking, etc.)?

\_\_\_\_\_  
\_\_\_\_\_

6. If you are beginning a regular exercise program, what type of exercise would you most like to do? \_\_\_\_\_

**SLEEP/REST**

- 1.a. Number of hours of sleep per night: \_\_\_\_\_
- b. Do you generally feel rested upon awakening?      Yes      No
- 2.a. Do you nap?      Yes      No
- b. Do you generally feel rested upon awakening?      Yes      No
- 3. Do you have problems with insomnia?      Yes      No  
If yes, please specify: \_\_\_\_\_
- 4. Do you use sleep aids?      Yes      No  
If yes, please specify: \_\_\_\_\_

**COGNITIVE/PERCEPTUAL**

- 1. Do you have any hearing difficulty?      Yes      No  
If yes, please specify: \_\_\_\_\_
- 2. Do you have any visual problems?      Yes      No  
If yes, please specify: \_\_\_\_\_
- 3. Do you have any learning difficulties?      Yes      No  
If yes, please specify: \_\_\_\_\_
- 4. Have you ever had a concussion?      Yes      No  
If yes, please specify: \_\_\_\_\_

**SELF-PERCEPTION/SELF-CONCEPT**

1. On a scale of 0 to 10, please rate your general sense of self-confidence:

0 1 2 3 4 5 6 7 8 9 10  
Not confident Very confident

2. List three things you like about yourself: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. List three things you would like to change about yourself: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Do you believe you experience any of the following feelings more often than most people (check all that apply)?

\_\_\_\_\_ fear                      \_\_\_\_\_ anxiety\_                      \_\_\_\_\_ lack of control  
\_\_\_\_\_ isolation                      \_\_\_\_\_ depression                      \_\_\_\_\_ hostility  
\_\_\_\_\_ anger                      \_\_\_\_\_ helplessness                      \_\_\_\_\_ hopelessness  
\_\_\_\_\_ guilt                      \_\_\_\_\_ shame                      \_\_\_\_\_ sadness

5. On a scale of 0 to 10, please rate how successful you feel that you will be in achieving your personal goals in this program (i.e. lose weight, stop smoking, improve focus, etc.):

0 1 2 3 4 5 6 7 8 9 10  
Not confident Very confident

**ROLE/RELATIONSHIP**

1. Marital status (please check one):

\_\_\_\_\_ married                      \_\_\_\_\_ single                      \_\_\_\_\_ living in a committed relationship  
\_\_\_\_\_ divorced                      \_\_\_\_\_ separated                      \_\_\_\_\_ widowed

2. Number of children: \_\_\_\_\_ Ages: \_\_\_\_\_ # at home: \_\_\_\_\_

3. How many people live in your household? \_\_\_\_\_

4. Education level completed (please circle the appropriate number):

Grade School                      High School                      College                      Graduate School  
1 2 3 4 5 6 7 8                      9 10 11 12                      13 14 15 16                      17 18 19 20 20+

5. Are you currently employed?                      Yes                      No  
If yes, occupation: \_\_\_\_\_  
If no, reason: \_\_\_\_\_

6. How many roles do you have? (please circle all that apply)  
 \_\_\_\_\_ friend      \_\_\_\_\_ child      \_\_\_\_\_ parent      \_\_\_\_\_ employer  
 \_\_\_\_\_ employee      \_\_\_\_\_ spouse      \_\_\_\_\_ caretaker      \_\_\_\_\_ community  
 \_\_\_\_\_ other (please specify): \_\_\_\_\_ volunteer

7. What resources do you have for emotional support? (please check all that apply):  
 \_\_\_\_\_ spouse      \_\_\_\_\_ family      \_\_\_\_\_ friends      \_\_\_\_\_ religious/spiritual  
 \_\_\_\_\_ pets      \_\_\_\_\_ other (please specify) \_\_\_\_\_

**STRESS/COPING**

1. Do you feel you have an excessive amount of stress in your life?      Yes      No

2. What is your perception of daily stressors which may interfere with you life? (please circle the number corresponding to each, 1 being no stress and 10 being the worst stress possible.)

Work	1	2	3	4	5	6	7	8	9	10
Family	1	2	3	4	5	6	7	8	9	10
Social	1	2	3	4	5	6	7	8	9	10
Finances	1	2	3	4	5	6	7	8	9	10
Health	1	2	3	4	5	6	7	8	9	10
Other	1	2	3	4	5	6	7	8	9	10

Please specify: \_\_\_\_\_

3. Do you meditate or practice a relaxation technique?      Yes      No

If yes, please check all that apply:

\_\_\_\_\_ yoga      \_\_\_\_\_ imagery      \_\_\_\_\_ abdominal breathing  
 \_\_\_\_\_ meditation      \_\_\_\_\_ Tai Chi      \_\_\_\_\_ progressive muscle relaxation  
 \_\_\_\_\_ prayer      \_\_\_\_\_ other: \_\_\_\_\_

4. Have you ever been abused, a victim of a crime, or experienced a trauma?      Yes      No

5. Where do you hold tension in your body? \_\_\_\_\_

6. How do you release muscular tension? \_\_\_\_\_

7. What do you do to calm your mind and emotions? \_\_\_\_\_

8. Do you feel you can easily handle the stress in your life?      Yes      No

**VALUES/BELIEFS**

1. What is valuable and meaningful to you in your life? \_\_\_\_\_  
\_\_\_\_\_
  
2. Do you have a religious orientation or belief system that supports you?    Yes                      No  
Please describe: \_\_\_\_\_  
\_\_\_\_\_
  
3. What is your motivation for enrolling in a Bio / Neurofeedback / Cognitive training program at this time?  
\_\_\_\_\_  
\_\_\_\_\_
  
4. What are the three most important goals that you hope to achieve during this program?  
  
#1 \_\_\_\_\_  
  
#2 \_\_\_\_\_  
  
#3 \_\_\_\_\_

Adapted from the clinical programs of the Division of Behavioral Medicine of the New England Deaconess Hospital (a Harvard teaching hospital) established by Herbert Benson, M.D. and Associates.