ADVANCED HEALTH & PERFORMANCE INSTITUTE

DR. PHILLIPS/WINDERMERE OFFICE
6735 CONROY-WINDERMERE ROAD
SUITE 309, ORLANDO, FL 32835

EVALUATION INTAKE FORM

To help us better customize our program to your family's personal needs and provide the smoothest experience we ask that you please fill out the following form:

Personal Information:

Today's Date: _____
Name: _____
M F
Birthdate: _____
Email Address: _____
Phone Number: _____

Physiological History:

- Abdominal Bloating
- Abdominal Pain
- Always Sickly
- Amnesia
- Anxiety Attacks
- Aphonia
- Back Pain
- Bulimia
- Burning pains
- Chest Pains
- Constipation
- Diarrhea
- Dizziness
- Dysmenorrhea
- Dysuria
- Extremity Pain
- Fainting Spells
- Fatigue
- Fits of convulsions
- Food intolerances
- Frigidity
- Had to quit working
- Headaches
- Heart Palpitations
- Insomnia
- Joint Pain
- Labored breathing
- Lump in throat
- Menstrual irregularity
- Nausea
- Other bodily pains
- Paralysis
- Phobias
- Ringing in ears
- Shaking or tremor
- Spasms
- Sudden weight fluctuation
- Tics-verbal or motor
- Unconsciousness
- Urinary retention
- Visual blurring
- Vomiting
- Weakness
- Weight loss

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Other Medical Problems:

- Alcoholism
- Chronic Illness
- Diagnosed illness
- Diagnosed mental disorder
- Drug addiction
- Emotional abuse
- Physical abuse
- Sexual abuse
- Terminal illness

Please provide detail for any of the items checked above:

_____
_____
_____
_____
_____
_____

What is the biggest problem?

How long has it been a problem?

What do you think caused it?

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MEDICAL HISTORY

If you have ever been diagnosed with one of the following, please place a mark next to it:

- ADD
- ADHD
- LD
- Depression
- Anxiety
- OCD
- Fibromyalgia
- Headache
- Chronic Fatigue
- Seizure Disorder
- PMS
- Addictive Disorder
- Allergies
- Panic Attack
- Autism Spectrum Disorder
- Migraine
- Insomnia
- TMJ
- Bruxism
- Tinitis
- Stroke
- Parkinsons
- Memory Problems
- Diabetes

Have you ever had:

Head Injury? _____ Age _____ Describe _____
Loss of consciousness? _____ Age _____ How long? _____
Describe

_____
_____
_____
_____
_____
_____

Allergies to food/medication? _____

List:

_____
_____
_____
_____

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Surgery? _____ Age _____ Reason _____ Describe _____
(if more than one surgery, please list on back)

Do you have high blood pressure? _____
Do you have a thyroid problem? _____
Do you have trouble going to sleep or staying asleep? _____
Were you ever in an auto accident? _____ If Yes, date?
_____
Do you smoke or drink caffeine? _____ how often? _____

Immunizations: When did you stop immunizing and what immunizations have you had.
What was the reason you stopped or did not start vaccinations?

_____
_____
_____

Doctors Seen:
Primary Care Physician: _____ Diagnosis:
Neurologist: - Date: _____Diagnosis
Suspected seizures, describe: _____
Diagnosed seizures, type: _____

Genetics – Date: _____ Diagnosis:
Psychiatry – Date: _____ Diagnosis:
Gastroenterology – Date: _____ Diagnosis:
Stomach/intestinal problems, type: _____
Endocrinology – Date: _____
Diagnostic Testing: (check all that apply)

- EEG (brain wave test) – Date: _____ Results:
- MRI – Date: _____ Results:
- CT Scan – Date: _____ Results:
- Chromosomal/DNA testing (Genetics) – Date: _____
- Other – Describe: _____

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Medication/Supplement History:
Current medications/supplements (Please note: DO CONTINUE TO ADMINISTER your regularly scheduled medications, if any, on the day of your brainmap appointment.)

Name of medication and or supplements	Dose & Frequency	Date Started	Reason	Effectiveness

Who prescribed these medications? _____

Please also list any medications your child has been on in the PAST:

Name of medication	Dose & Frequency	Date Started	Reason	Effectiveness

Who prescribed these medications? _____

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PRESENTING SYMPTOMS:

Please place a mark next to any of the following items that describe your currently or in the past.

- Trouble filtering out background noises
- Difficulty adding numbers in your head
- Forget what you (did) had to eat the day before
- Difficulty remembering a phone number long enough to dial it
- Trouble remembering names
- Wandering while having a conversation
- Difficulty paying attention to a presentation
- Short attention span
- Rigidly stick to the same solution
- Difficulty multitasking
- Frequently saying things that shock others
- Trouble controlling your emotions
- Blurting out things that you later regret saying
- Having to re-read a paragraph several times before it sinks in
- Uncontrollable episodes of anger
- Getting stuck on ideas, thoughts, or behaviors
- Trouble finding your car in the parking lot
- Getting lost easily in buildings or malls
- Feeling aware of everything going on around you all the time
- Ruminating over your To Do List constantly
- Constant worrying
- Panic attacks
- Depressive feelings

PLEASE BRING THIS COMPLETED FORM TO YOUR FIRST APPOINTMENT