Name ____ Date___________________________________

Gender___________________ Age _______________

Primary concerns ____

____

Occupation ____

Current medications or non-prescription supplements
Please note that after 10 sessions of neurofeedback, medication effects may be enhanced. Please inform your medication provider that medication may need to be reduced.

Current or prior medical concerns/diagnosis?

IF YOU HAVE THESE SYMPTOMS, EXPLAIN & RATE THEM ON A SCALE OF 1 – 10 WITH 1 BEING THE LOWEST DIFFICULTY & 10 BEING A MAJOR DIFFICULTY

Sleep

How many hours of sleep do you get at night?

What time do you go to bed?

What time do you wake up?

Difficulty falling sleep

Racing thoughts (can't turn off thoughts to fall asleep)

Difficulty staying asleep

How many times do you wake up?

How long are you awake, if you awake in the middle of the night?

Restless sleep

Night-terrors

Sleep walking or talking

Restless leg

Not rested after sleep

Sleep apnea / snoring

Narcolepsy

Pain

Headaches & how often

Migraines & how often

Stomach pain

Muscle tension pain

Arthritis (joint) pain

Chronic nerve pain

High pain tolerance

Physical

Balance

Coordination

Tremor

Hyperactivity

Tics

Teeth Grinding

Muscle weakness

Physiology

Allergy

Asthma

Diabetes

Autoimmune

High blood pressure

Frequent illness

Nausea or vomiting

Dizziness / fainting

PMS / menopausal symptoms

Thyroid / endocrine

Incontinence / enuresis (urinary accidents)

Chronic constipation / irritable bowel

Emotions

Anxiety

Where do you feel anxiety in your body?

Restlessness/feeling on edge/difficulty being still or difficulty relaxing

Irritabilty

Fear

Obsessive worries (issues you can not stop thinking about)

Depression

Emotional reactivity

Phobias

Suicidal thoughts

Mood swings

Panic attacks

Lack of empathy

Behavior

Impulsive

Compulsive

Oppositional

How many times is a task requested before it is attempted?

Tantrums / rages   How often? What sets tantrums / rages off?

Aggressive

Thrill seeking

Self-injury

Addiction

Eating disorders

Attention

Focused attention

Organization and planning

Memory

Body awareness

Appetite awareness

Space and time awareness

Attention to detail

Follow through/ completing tasks or projects

Sensory / Cognitive

Vision

Hearing

Tinnitus

Verbal expression

Reading / writing

Math

Drawing

Sense of direction

Common sense

Birth and early development

In utero or birth trauma

Early developmental problems

Early trauma or neglect

Adopted

Attachment problems

Brain injury

Seizures

High fever

Traumatic brain injury

Stroke

Other brain injury

Traumatic experiences

Physical trauma (injuries)

Emotional trauma

Therapies

Psychotherapy

Physical therapy

Occupational therapy

Other

Drug experience / How often

Would you or someone you know say that you have a problem with drugs or alcohol?

Marijuana

Other

Caffeine

Alcohol

Nicotine

Family and relationships

Who is in your immediate family? (parents, brothers, sisters, children, etc.)

How are the relationships in your family and with friends?

Do you have issues with co-workers, neighbors, etc?

Are you in a significant romantic relationship? (married, boy/girl friend)

Significant prior relationship (divorced, widowed, etc.)? Yes No

Number of children and ages (if applicable):____

What is the highest grade you completed?

What do you like to do for fun or hobbies?

Legal

Have you ever been arrested? Served time in jail or prison?

Have you been in trouble at school or with the law?

Work

What is your work history like?

How long do you normally keep a job?

Do you have an income?

Do you receive financial assistance?

Mental Health

Any thing else we have not asked that you would like to tell us?