Name: _____ Date: _____

Please rate all symptoms on a scale of 0--10 on the level of difficulty for you

Attention and Learning

____ Constant fidgeting / hyperactivity
____ Completing tasks / follow-thru
____ Focusing / listening / distractable
____ Following instructions /directions
____ Hyperfocus / fixates on a tasks
____ Inflexibility / difficulty with change
____ Lack of alertness
____ Lacking common sense
____ Making decisions
____ Planning and/or organizing
____ Poor math skills
____ Poor memory/ forgetful
____ Poor verbal expression
____ Procrastination
____ Reading difficulty
____ Time and/or body awareness
____ Remembering names / word recall
____ Shifting attention to another task
____ Thinking clearly / foggy
____ Understanding / keeping up with conversations
____ Unmotivated

Behavioral

____ Addictive behaviors
____ Appetite awareness
____ Aggressive behavior verbal / physical to people or objects
____ Anorexia / severely controlling intake of calories
____ Autistic stimming / flapping
____ Binging / purging food /uncontrollable eating & throwing up
____ Class clown / blurting out
____ Compulsive / performing an act repetitively rituals
____ Compulsive eating / uncontrollable eating
____ Excessively emotional / crying
____ Exaggerated startle response
____ Hoarding / attachment to & difficulty throwing away items
____ Hypervigilance / high alert
____ Inflexibility / difficulty with change
____ Impulsivity / acting without thinking
____ Lack of sense of humor
____ Lack of social interest
____ Manipulative behavior
____ Motor or vocal tics
____ Oppositional / defiant
____ Nail biting
____ Poor eye contact
____ Poor grooming
____ Pressured speech /urgent rapid excessive talking
____ Poor social skills
____ Poor speech articulation
____ Rages
____ Reciprocity /conversational
____ Risky sexual behavior
____ Self-injurious behavior
____ Stuttering
____ Tantrums / rages

Emotional

____ Agitation / observable physical anxiety
____ Anger
____ Anxiety
____ Awkwardness
____ Depression
____ Dissociative episodes not remembering blocks of time zoning out/
____ Fears / phobias
____ Difficult to soothe
____ Emotionally reactive
____ Feeling life or self is not real
____ Flashbacks of trauma
____ Impatience
____ Irritability
____ Lack of social awareness
____ Lack of pleasure
____ Low self-esteem
____ Mania / days of excessive energy & days of not sleeping
____ Mood swings / daily
____ Obsessive negative thoughts
____ Obsessive worries
____ Paranoia
____ Suicidal thoughts

Name: _____ **Date:** _____-

Pain

____ Abdominal / stomach pain
____ Chronic muscle pain
____ Chronic nerve pain / Sciatica back, hips, legs, feet
____ Fibromyalgia pain
____ Headaches
____ Jaw pain
____ Joint pain (arthritis
____ Migraine headaches
____ Pain on face from touch / Trigeminalia neuralgia

Physical

____ Autoimmune
____ Allergies
____ Asthma
____ Chronic constipation
____ Clumsiness / balance issues
____ Diabetes
____ Dizziness / fainting / balance / vertigo
____ Fatigue
____ Frequent Illness
____ Heart palpitations
____ High blood pressure
____ Hot flashes
____ Immune deficiency
____ Irritable bowel
____ Low muscle tone / hypotonia
____ Loss of bowel control
____ Muscle tension
____ Muscle twitches
____ Muscle weakness / rigidity
____ Nausea / vomiting
____ PMS symptoms / menopausal symptoms
____ Poor fine motor skills / fingers, toes, tongue
____ Poor gross body skills/ stand, walk, jump
____ Reflux
____ Seizures
____ Skin rashes
____ Spasticity / muscles continuously contracted
____ Stress incontinence
____ Sugar craving and reactivity
____ Sweating excessively
____ Tachycardia / fast resting heart rate
____ Tics
____ Tremor / trembles or shaking
____ Urinary accidents

Sensory

____ Auditory / noise hypersensitive
____ Chemical sensitivity / red skin, burning, rashes, hives, etc
____ Motion sickness
____ Poor body awareness / clumsy
____ Ringing in ears / tinnitus
____ Sensitive to textures, touch
____ Vertigo / dizziness, balance, swaying
____ Visual Deficit
____ Visual hypersensitivity or overwhelm

Sleep

____ Bed wetting
____ Daytime excessive sleepiness (Narcolepsy)
____ Difficulty falling asleep
____ Difficulty staying asleep
____ Nightmares or vivid dreams
____ Night sweats
____ Night terrors / wake screaming
____ Not feeling rested when waking
____ Racing thoughts
____ Restless sleep
____ Restless Leg Syndrome
____ Sleep apnea / snoring
____ Sleep talking
____ Sleep walking
____ Teeth grinding

Other

____ Energy Level
____ Confidence

Sexual Difficulties

____ Impotence (inability to achieve erection or orgasm) ____Low Libido ____Painful intercourse

If you are filling this out at the end of your sessions:

When we are living with symptoms, they feel normal to us. When you think back before NFB, do you think your symptoms were higher than what you initially rated them?

_____ Are you happy with the results? Please rate & explain