EEG NEUROFEEDBACK – INTAKE / HISTORY

Name of Client: _____ Age: _____ DOB: _____
Address: _____
City/State/Zip: _____
Phone: (home) _____ (work) _____ (fax) _____

Parent(s) or Guardian(s) of minor:

Name(s): _____
Address: (if different from above) _____
City/State/Zip: _____
Phone: (home) _____ (work) _____ (fax) _____

Physician / other health care professional (chiropractor, therapist, naturopath, bodyworker, etc):

Name: _____ Phone: _____
Referral source if referred to this office: _____ **Phone:** _____
Diagnosis: _____ **Current medications:** _____
_____

Insurance Information:

Insurance company name: _____
Your policy number: _____ Group number: _____
Name of insured: _____ DOB: _____
Relationship to client: _____ Employer: _____
Briefly list other approaches you have tried for this condition: (Medication, behavior therapy, counseling, alternative medicine, etc.?)

_____
_____

What benefits do you hope to gain from EEG neurofeedback?: _____
_____
_____

Developmental History – Please indicate your (or your child's) history in relation to the following:

Prenatal and Birth	**Yes**	**No**	**Details**
Prenatal stress or injury	___	___	_____
Prenatal drug/alcohol exposure	___	___	_____
Birth trauma (forceps, breech, etc.)	___	___	_____
Anesthesia, pain medications	___	___	_____
Anoxia (oxygen deprivation @ birth)	___	___	_____
Premature/late delivery	___	___	_____
Medical problems after birth	___	___	_____

Birth weight _____ Adopted at age _____ Other _____

Growth and Development	Typical	More	Less	Details
Activity level				
Motor/coordination development				
Infections/allergies				
Emotional development				
Behavior concerns				
Handedness development				
Appetite/digestion				
Language/speech development				

Physical Traumas	Yes	No	Details
Head injury (even minor falls, etc.)			
Coma (loss of consciousness)			
Accidents (list all)			
High fever			
Serious illness			
Surgery			
CNS infection			
Drug overdose/poisoning			
Recreational drug use			
Anoxia			
Stroke			

Psychological Stress/Life Changes	Yes	No	Details
Death in family			
Divorce/remarriage			
Move/relocation			
School change			
Job change			
Family member chronic illness			

Symptom Checklist

Please indicate if the **client** and/or **family member(s)** (parents, grandparents, brothers, sisters, aunts, uncles, and/or children) **currently experience** or have a **history** of any of the following symptoms.

Symptom	√ if client	√ if family	√ if current	Symptom	√ if client	√ if family	√ if current
Feeling Tense				Shy with People			
Depressed				Allergies			
Always on the go				Asthma			
School/work problem				Seizures			
Impulsivity				Chronic pain			
Hyperactivity				Food sensitivity			
Attention problems				Head injury			
Behavior problems				Memory problems			
Vocal or motor tics				Temper tantrums			
Sleep problems				Rages			
Legal trouble				Verbal Aggression			
Headaches				Physical Aggression			
Feeling lonely				Stubbornness			
Frequent illness				Addictions			
Repetitive thoughts				Bowel disturbances			
Repetitive behavior				Chronic fatigue/FMS			

Inferiority feelings	____	____	____
Dizziness	____	____	____
Fainting spells	____	____	____
Heart palpitations		____	____
_____			
Stomach trouble	____	____	____
Poor appetite	____	____	____
Picky eater	____	____	____
Nightmares	____	____	____
Alcohol/drug problem	____	____	____
Feeling panicky	____	____	____
Tremors	____	____	____
Suicidal ideas	____	____	____

PMS	____	____	____
Physical/sexual abuse	____	____	____
Over ambitious	____	____	____
Unable to relax	____	____	____
Can't make decisions	____	____	____
Communication prob.	____	____	____
Problems at home	____	____	____
Financial problems	____	____	____
Any chronic illness	____	____	____

Other, specify: _____

Please circle the **five current problems** listed above which are the **most distressing** to you or your child.

Therapists comments: _____

Symptom Checklist

Mark all boxes across from each of your symptoms. Mark only current or recent symptoms (6 months)

Depressed			
(unhappy, low)	☐		☐
(angry and controlling)		☐	☐
Impulsive / hyperactive		☐	
Inattentive / daydreams	☐		
Shy	☐		☐
Oppositional		☐	
Lacks empathy		☐	☐
Anxious		☐	☐
Poor language skills	☐		
Unmotivated	☐		☐
Misses social cues	☐		☐
Fearful		☐	☐
Poor sequential processing	☐		
Impatient		☐	☐
Obsessive-compulsive		☐	
Emotionally sensitive	☐		☐
Poor drawing and spatial skills	☐		
Tics (with stress)		☐	
Irritable	☐		
Easily frustrated		☐	
Manipulative, aggressive, no remorse	☐	☐	
Holds a grudge		☐	☐
Remorseful after tantrums	☐		
Teased by peers	☐		☐
Poor spatial skills		☐	
Recovers quickly from tantrums		☐	
Poor math concepts		☐	
Socially aloof	☐		☐
Stomachaches (with stress)		☐	☐
Lack of body awareness		☐	☐
High threshold for pain		☐	☐
Speech lacks intonation	☐		
Poor sense of appetite		☐	
Problems staying asleep	☐		☐
Problems falling asleep		☐	☐
Enuresis (bedwetting)	☐	☐	
Bruxism (teeth grinding)	☐	☐	☐
Encopresis (soiling)		☐	☐
Rushes through work		☐	☐
Restless sleep		☐	☐
Sleep walking and talking	☐	☐	☐
Narcolepsy (can't stay awake)	☐	☐	☐

Generalized anxiety		☐	☐
Chronic pain (injury)	☐		☐
Tension headaches	☐	☐	☐
Panic attacks		☐	☐
Perfectionist	☐		☐
Loud unmodualted voice		☐	
Slow processing, slow response	☐		
Nightmares		☐	☐
Poor eye contact		☐	☐
Migraines	☐	☐	☐
Binge eating	☐		☐
Rages, loss of control	☐		☐
Mood unrelated to life events	☐		☐
Autistic symptoms		☐	
Sugar cravings	☐		
PMS	☐	☐	
Poor reading comprehension	☐		
Poor sense of direction	☐	☐	
Fibromyalgia	☐	☐	☐
Tight muscles / muscle strain		☐	
Difficulty understanding concepts	☐		
Allergies and asthma	☐	☐	
Immune deficiency	☐		
Hypoglycemia	☐	☐	
Chronic Fatigue Syndrome	☐	☐	☐
Autoimmune disease	☐	☐	☐
Hot flashes		☐	
Poor word fluency	☐		
Chronic burning pain		☐	
Poor visual tracking	☐		
Aggressive, controlling		☐	☐
Bipolar disorder	☐	☐	☐
Physical agitation		☐	☐
Lack of feeling of well-being	☐		☐
Compulsive overeating		☐	☐
Intolerant of stimulants		☐	
Anorexia, bulimia with:			
depression and PTSD	☐		☐
anxious and controlling		☐	☐
	BL	SR	AT
Totals:	___	___	___

Head Injury Questionnaire

This questionnaire is designed to determine whether you have ever had a significant injury to your brain. Please read the questions carefully and think carefully about your history. It is common for people to forget head injuries, car accidents, minor falls, etc. when they are not followed by a loss of consciousness or significant impairment.

Event	Yes	No	List events and dates	Low - Severity - High
Have you ever had an injury involving an impact to your head?			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s ____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____	Length of time unconscious: _____
Were you ever in a motor vehicle, skate board, skiing, bike or other accident?			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s ____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____	Length of time unconscious: _____
Were you told that you fell as a child (down stairs, off a table or chair, at a park?)			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s ____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____	Length of time unconscious: _____
Ever been in a fight, been beaten or attacked, passed out from alcohol?			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s ____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____	Length of time unconscious: _____

Symptoms persisting after event	Yes	No	Describe – How long?	Low - Severity - High
Headache – tension and/or migraine				1 2 3 4 5 6 7 8 9 10
Tinnitus				1 2 3 4 5 6 7 8 9 10
Light headed				1 2 3 4 5 6 7 8 9 10
Impaired memory				1 2 3 4 5 6 7 8 9 10
Reduced attention span				1 2 3 4 5 6 7 8 9 10
Easily distractible				1 2 3 4 5 6 7 8 9 10
Impaired comprehension				1 2 3 4 5 6 7 8 9 10
Forgetful				1 2 3 4 5 6 7 8 9 10
Frustration				1 2 3 4 5 6 7 8 9 10
Problems with logical thinking				1 2 3 4 5 6 7 8 9 10
Trouble with abstract concepts				1 2 3 4 5 6 7 8 9 10
Anxiety				1 2 3 4 5 6 7 8 9 10
Depression				1 2 3 4 5 6 7 8 9 10
Insomnia				1 2 3 4 5 6 7 8 9 10
Apathy				1 2 3 4 5 6 7 8 9 10
Fatigue				1 2 3 4 5 6 7 8 9 10
Irritability				1 2 3 4 5 6 7 8 9 10
Angry outbursts				1 2 3 4 5 6 7 8 9 10
Mood swings				1 2 3 4 5 6 7 8 9 10
Hyper acute or diminished senses				1 2 3 4 5 6 7 8 9 10
Dizzy				1 2 3 4 5 6 7 8 9 10
Reduced libido				1 2 3 4 5 6 7 8 9 10
Intolerance for alcohol or caffeine				1 2 3 4 5 6 7 8 9 10
Reduced motivation				1 2 3 4 5 6 7 8 9 10

Wender-Utah Rating Scale of Childhood AD/HD

	As a child I was (or had):	Not at all or very slightly	Mildly	Moderately	Quite a bit	Very much
1	Active, restless, always on the go					
2	Afraid of things					
3	Concentration problems, easily distracted					
4	Anxious, worrying					
5	Nervous, fidgety					
6	Inattentive, daydreaming					
7	Hot or short tempered, low boiling point					
8	Shy, sensitive					
9	Temper outbursts, tantrums					
10	Trouble with stick-to-it-iveness, not following through, failing to finish things started.					
11	Stubborn, strong willed					
12	Sad or blue, depressed, unhappy					
13	Incautious, dare-devilish, involved in pranks					
14	Not getting a kick out of things, dissatisfied with life					
15	Disobedient with parents, rebellious, sassy					
16	Low opinion of myself					
17	Irritable					
18	Outgoing, friendly, enjoyed company of people					
19	Sloppy, disorganized					
20	Moody, ups and downs					
21	Angry					
22	Friends, popular					
23	Well-organized, tidy, neat					
24	Acting without thinking, impulsive					
25	Tendency to be immature					
26	Guilty feelings, regretful					
27	Losing control of myself					
28	Tendency to be or act irrational					
29	Unpopular with other children, didn't keep friends for long, didn't get along with other children					
30	Poorly coordinated, did not participate in sports					
31	Afraid of loosing control of self					
32	Well coordinated, picked first in games					
33	Tomboyish (for women only)					

	As a child I was (or had):	Not at all or very slightly	Mildly	Moderately	Quite a bit	Very much
34	Running away from home					
35	Getting into fights					
36	Teasing other children					
37	Leader, bossy					
38	Difficulty getting awake					
39	Follower, led around too much					
40	Trouble seeing things from someone else's point of view					
41	Trouble with authorities, trouble with school, visits to principal's office					
42	Trouble with police, booked, convicted					
	Medical Problems as a Child:					
43	Headaches					
44	Stomachaches					
45	Constipation					
46	Diarrhea					
47	Food allergies					
48	Other allergies					
49	Bedwetting					
	As a child in school I was (or had):					
50	Overall a good student, fast					
51	Overall a poor student, slow learner					
52	Slow in learning to read					
53	Slow reader					
54	Trouble reversing letters					
55	Problems with spelling					
56	Trouble with mathematics or numbers					
57	Bad handwriting					
58	Able to read pretty well but never enjoyed reading					
59	Not achieving up to potential					
60	Repeating grades (which grades? ___)					
61	Suspended or expelled (which grades? ___)					