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INTAKE/PSYCHOSOCIAL HISTORY FOR NEUROFEEDBACK

ADOLESCENT and ADULT FORMS

FOR NEUROFEEDBACK CLIENTS:

Please fill out the attached forms as completely as you can. The more we know about your symptoms and history the better we can choose neurofeedback protocols for you. It helps to know of any past abuse and drug use, but if any questions make you feel uncomfortable, leave them blank. Once again, please remember that the information that you provide is used for creating the best treatment plan for you and ALL information remains confidential.

The first appointment, will last approximately 45-60 minutes. At that appointment we will give you instructions about setting up additional appointments. After 20 sessions we will discuss your progress and make treatment plan determinations about further appointments.

We look forward to working with you!

Neurofeedback Assessment Questionnaire

Today's Date: _____

Name:_____ Age: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number	May we leave a message for you?
Home: _____	☐ Yes ☐ No
Work: _____	☐ Yes ☐ No
Cell: _____	☐ Yes ☐ No

Occupation: _____ How Long: _____

Email: _____

Are you currently attending college or a trade school? ☐ Yes ☐ No

If yes, what school? _____

What is your major or trade of study? _____

How were you referred to our office? _____

Sex: M F	Handedness: R L Mixed

Presenting Problem(s):

Why are you seeking Neurofeedback treatment? _____

_____

_____

_____

It is important to know whether you have any of these symptoms presently, or have ever had them. Please check any that apply to you. Then Scale from 0-10.

Scale: 0 = no problem; 10 = serious problem or difficulty for you

ATTENTION SYMPTOMS	✓	Rank 0-10	
			ADD (inattentive type)
			Inattention (internal)
			Daydreaming
			Poor concentration
			Lack of motivation
			Impulsivity
			Distractibility (external)
			Stimulus seeking (internal)

✓	Rank 0-10	
		Thrill seeking (external)
		Competing thoughts; too many thoughts
		ADHD (Attention Deficit/ Hyperactivity Disorder)
		Hyperactivity after sugar
		Hyperactivity after sedatives
		Overwhelmed by stimuli
		Hard to make decisions (executive function)
		Disorganized

SLEEP SYMPTOMS	✓	Rank 0-10	
			Night sweats
			Frequent waking during night (without agitation)
			Sleep lightly
			Sleeping too much
			Sleep apnea
			Snoring
			Not rested after sleep
			Waking early
			Physically restless sleep
			Nightmares (bad dreams)

✓	Rank 0-10	
		Restless leg syndrome
		Vivid dreams
		Clenching jaw
		Waking with agitation
		Sleep walking
		Sleep talking
		Too busy to sleep (manic)
		Teeth grinding
		Night terrors-with screaming, don't remember in morning

How long does it take for you to fall asleep? _____

How many hours of sleep do you get a night? _____

What time do you tend to go to bed? _____

What time do you get up? _____

EMOTIONAL AND BEHAVIORAL SYMPTOMS	✓	Rank 0-10		✓	Rank 0-10	
			Anxiety			Agitation (upset/emotional more often than not)
			Depression			Mania
			Feelings easily hurt			Paranoia
			Perfectionist			Suicidal thoughts or actions
			Remorseful after tantrums			Shame
			Rages			Compulsive behavior
			Cries easily (feelings hurt)			Obsessive thoughts
			Guilt			Involuntary movement or tics
			Withdraws when stressed			Impatient
			Passive			Aggressive - initiates conflicts
			Posttraumatic stress disorder			Jealous/envious
			Grumpy			Angry
			Borderline personality disorder			Rumination
			Thinks little of self			Hates self
			Performance anxiety			Dissociative
			Shy			Lacks empathy
			Seasonal affective disorder			Lacks cause and effect thinking
			Fidgets			Manipulative, controlling
			Whining			Holds a grudge
			Dissociative identity disorder (multiple personalities)			Poor comprehension and expression of emotions
			Loud, unmodulated voice			Lack of body awareness (pain, discomfort)
			Poor eye contact			Binge eating
			Poor social awareness			Anorexia
			Autistic symptoms			Bulimia
			Motor or vocal ties			Bipolar (manic-depressive cycles)
			Road rage			Panic attacks
			Nail biting, nervous habits			Encopresis (soiling)
			Attachment disorder (history)			Enuresis (bed wetting)

COGNITIVE SYMPTOMS	✓	Rank 0-10		✓	Rank 0-10	
			Dyslexia			Poor sense of self in space
			Poor word fluency			Poor drawing
			Poor sequential processing			Inability to write neatly (even slowly)
			Poor sequential planning			Poor fine motor skills
			Poor reading comprehension			Poor math concepts
			Difficulty decoding words			Poor spelling
			Poor arithmetic calculation			Poor tracking during reading
			Indecisive			Lack of prosody in speech (monotone speech)
			Non-verbal learning disabilities			Poor sense of direction
			Poor visual-spatial skills			Do not know left from right

PAIN SYMPTOMS	✓	Rank 0-10		✓	Rank 0-10	
			Chronic pain with depression			Jaw tension
			Headache			Shoulder pain
			Low pain threshold			Neck pain
			Fibromyalgia			Sciatica pain
			Complex regional pain			Peripheral neuropathy pain
			Amplified pain syndrome			Emotional reactivity to pain

NEUROLOGICAL AND MOTOR SYMPTOMS	✓	Rank 0-10		✓	Rank 0-10	
			Tinnitus (ringing in the ears)			Vertigo (dizziness)
			Traumatic brain injury			Tremors
			Poor balance			Seizures: if yes, what kind?
			Poor coordination			
			Nervous habits/laugh			Tics: if yes, what type?

SENSORY INTEGRATION

Do tags on shirts, seams on socks or certain fabrics bother you? ☐ Yes ☐ No

Are you more sensitive to the environment than others? ☐ Yes ☐ No

Do you have an unusual sensitivity to light? ☐ Yes ☐ No

Do you have an unusual sensitivity to certain smells? ☐ Yes ☐ No

Do you have an unusual sensitivity to sounds? ☐ Yes ☐ No

Are you clumsy or accident-prone? ☐ Yes ☐ No

IMMUNE, ENDOCRINE & ANS SYMPTOMs	✓	Rank 0-10		✓	Rank 0-10	
			Immune Deficiency			High blood pressure
			Low thyroid function			Low blood pressure
			Irritability			Severe PMS
			Mood Swings			Chronic fatigue syndrome
			Insomnia			Asthma
			Migraines			Heart palpitations
			Racing thoughts			Diabetic controlled by: ☐ diet ☐ exercise What type: ☐1 ☐ 2 ☐ GDM Medication:
			Autoimmune disorders describe:			

GASTROINTESTINAL SYMPTOMS	✓	Rank 0-10		✓	Rank 0-10	
			Reflux			Celiac disease
			Constipation			Irritable bowel syndrome
			Chron's disease			Gastroesophageal reflux disease
			Ulcerative Colitis			Abdominal pain

HISTORY

Prenatal, birth events, and/or injuries such as stress injury, drug exposure, difficult labor, forceps delivery, breech birth, induced labor, Pitocin, anesthesia, anoxia, premature/late delivery, or post –birth problems? Other? Please describe.

_____

_____

_____

Problems with growth and development such as severe or recurrent illness or infections, allergies, emotional difficulties, behavioral problems, appetite/digestion, language/speech, coordination? Walking or talking early? Walking or talking late? Early, late or no crawling? History of ear infections? Please describe.

_____

_____

_____

Please indicate if you have ever experienced any of the following and if yes, please describe:

Physical trauma ☐ Yes ☐ No
Date: _____ Describe: _____
Injury ☐ Yes ☐ No
Date: _____ Describe: _____
Coma ☐ Yes ☐ No
Date: _____ Describe: _____
Accidents ☐ Yes ☐ No
Date: _____ Describe: _____
High fever ☐ Yes ☐ No
Date: _____ Describe: _____
Serious illness ☐ Yes ☐ No
Date: _____ Describe: _____
Surgery ☐ Yes ☐ No
Date: _____ Describe: _____
CNS infection ☐ Yes ☐ No
Date: _____ Describe: _____
Poisoning ☐ Yes ☐ No
Date: _____ Describe: _____
Anoxia ☐ Yes ☐ No
Date: _____ Describe: _____
Stroke ☐ Yes ☐ No
Date: _____ Describe: _____
Heart attack ☐ Yes ☐ No
Date: _____ Describe: _____
Have you/your child ever been to the Emergency Room? ☐ Yes ☐ No
Date: _____ Describe: _____

_____

HISTORY CONTINUED

Psychological stresses/life changes, especially during childhood such as a death, divorce, loss, move, school change, job change, illness? Has your child experienced emotional, physical or sexual abuse or neglect? Please describe.

_____

_____

_____

Currently or recently on any medications, drugs, hormone replacements, allergy or asthma treatments, alternative therapies, nasal sprays? Other? Please list name, dosage and indication for use:

Medication Name	Dose	Frequency	Used For
1.			
2.			
3.			
OTC Medications, Herbals, etc.			
4.			
5.			

Surgeries, hospitalizations, or medical treatments? Was either general or local anesthesia used? Please describe.

_____

_____

_____

Any psychological therapies (psychologist, social worker, family therapist)? Are you currently in psychotherapy? If so, with whom? Have you ever been given a psychiatric diagnosis?

_____

_____

_____

Any educational therapies (tutors, special schools, resource teacher, vision therapy, etc.)? Please describe.

_____

_____

_____

Any neurological or educational testing? Do you have copies of these tests or the results?

_____

_____

_____

FAMILY HISTORY: Have any close relatives experienced problems such as epilepsy, autism, Asperger's, alcoholism, mental illness, depression, suicide, incarceration or any of the other problems reviewed in this assessment? Please describe.

_____

_____

_____

LIFESTYLE INVENTORY:

Recreational drug use? If so, when, what drugs and how did each effect you?

_____

_____

_____

Do you drink alcohol? ☐ Yes ☐ No
If so, how often? _____How much? _____
Do you drink caffeine (soda, tea, coffee)? ☐ Yes ☐ No
If so, how much? _____When during the day? _____
Do you smoke? ☐ Yes ☐ No
If so, how many cigarettes per day? _____ How long have you smoked? _____
How many hours per day do you watch TV? _____
On weekdays? _____On weekends? _____
Do you play computer/video/tablet games? ☐ Yes ☐ No How many hours a week? _____
Do you exercise? ☐ Yes ☐ No
What form(s)?_____ How many times a week? _____
Do you read for pleasure? ☐ Yes ☐ No
What do you do to relax? _____