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**INTAKE/PSYCHOSOCIAL HISTORY FOR NEUROFEEDBACK
CHILD 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: _____

Client Name: _____ Age: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Phone Number

May we leave a message for you?

Home: _____ Yes No

Work: _____ Yes No

Cell: _____ Yes No

School: _____ How Long: _____

How were you referred to our office? _____

Sex: M F

Handedness: R L Mixed

Presenting Problem(s):

Why are you seeking Neurofeedback treatment? _____

Family Information and History:

Who does the child reside with? Please check all that apply and list the percent of time that child reside with each listed person.

<input type="checkbox"/>	Both natural parents - % time	_____
<input type="checkbox"/>	Natural mother - % time	_____
<input type="checkbox"/>	Natural Father - % time	_____
<input type="checkbox"/>	Stepmother - % time	_____
<input type="checkbox"/>	Stepfather - % time	_____
<input type="checkbox"/>	Guardian, please specify:	_____
<input type="checkbox"/>	Other: please specify	_____

Please list the address for each person that the child resides with:

Person #1: _____
 Address _____ Email _____
 City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Occupation _____ Employer _____

Person #2: _____
 Address _____ Email _____
 City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Occupation _____ Employer _____

Person #3: _____
 Address _____ Email _____
 City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Occupation _____ Employer _____

Person #4: _____
 Address _____ Email _____
 City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Occupation _____ Employer _____

Please list all siblings (whether they reside with your child or not). Use back side of this page if needed.:

Name age/ of Sibling 1:	Resides with Relationship/Name:	Address Phone/Number:
Name age/ of Sibling 2:	Resides with Relationship/Name:	Address Phone/Number:
Name age/ of Sibling 3:	Resides with Relationship/Name:	Address Phone/Number:
Name age/ of Sibling 4:	Resides with Relationship/Name:	Address Phone/Number:

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/your child. Then Scale from 0-10.

Scale: 0 = no problem; 10 = a high level of problem or difficulty.

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		
				Anxiety
				Depression
				Feelings easily hurt
				Perfectionist
				Remorseful after tantrums
				Rages
				Cries easily (feelings hurt)
				Guilt
				Withdraws when stressed
				Passive
				Posttraumatic stress disorder
				Grumpy
				Borderline personality disorder
				Thinks little of self
				Performance anxiety
				Shy
				Seasonal affective disorder
				Fidgets
				Whining
				Dissociative identity disorder (multiple personalities)
				Loud, unmodulated voice
				Poor eye contact
				Poor social awareness
			Autistic symptoms	
			Motor or vocal ties	
			Road rage	
			Nail biting, nervous habits	
			Attachment disorder (history)	

✓	Rank 0-10	
		Agitation (upset/emotional more often than not)
		Mania
		Paranoia
		Suicidal thoughts or actions
		Shame
		Compulsive behavior
		Obsessive thoughts
		Involuntary movement or tics
		Impatient
		Aggressive - initiates conflicts
		Jealous/envious
		Angry
		Rumination
		Hates self
		Dissociative
		Lacks empathy
		Lacks cause and effect thinking
		Manipulative, controlling
		Holds a grudge
		Poor comprehension and expression of emotions
		Lack of body awareness (pain, discomfort)
		Binge eating
		Anorexia
		Bulimia
		Bipolar (manic-depressive cycles)
		Panic attacks
		Encopresis (soiling)
		Enuresis (bed wetting)

COGNITIVE SYMPTOMS	✓	Rank 0-10		
				Dyslexia
				Poor word fluency
				Poor sequential processing
				Poor sequential planning
				Poor reading comprehension
				Difficulty decoding words
				Poor arithmetic calculation
				Indecisive
				Non-verbal learning disabilities
				Poor visual-spatial skills

✓	Rank 0-10	
		Poor sense of self in space
		Poor drawing
		Inability to write neatly (even slowly)
		Poor fine motor skills
		Poor math concepts
		Poor spelling
		Poor tracking during reading
		Lack of prosody in speech (monotone speech)
		Poor sense of direction
		Do not know left from right

PAIN SYMPTOMS	✓	Rank 0-10	
			Chronic pain with depression
			Headache
			Low pain threshold
			Fibromyalgia
			Complex regional pain
			Amplified pain syndrome

✓	Rank 0-10	
		Jaw tension
		Shoulder pain
		Neck pain
		Sciatica pain
		Peripheral neuropathy pain
		Emotional reactivity to pain

NEUROLOGICAL AND MOTOR SYMPTOMS	✓	Rank 0-10	
			Tinnitus (ringing in the ears)
			Traumatic brain injury
			Poor balance
			Poor coordination
			Nervous habits/laugh

✓	Rank 0-10	
		Vertigo (dizziness)
		Tremors
		Seizures: if yes, what kind?
		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	
			Immune Deficiency
			Low thyroid function
			Irritability
			Mood Swings
			Insomnia
			Migraines
			Racing thoughts
			Autoimmune disorders describe:

✓	Rank 0-10	
		High blood pressure
		Low blood pressure
		Severe PMS
		Chronic fatigue syndrome
		Asthma
		Heart palpitations
		Diabetic controlled by: <input type="checkbox"/> diet <input type="checkbox"/> exercise What type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> GDM Medication:

GASTROINTESTINAL SYMPTOMS	✓	Rank 0-10	
			Reflux
			Constipation
			Chron's disease
			Ulcerative Colitis

✓	Rank 0-10	
		Celiac disease
		Irritable bowel syndrome
		Gastroesophageal reflux disease
		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?