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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.

- ☐ Both natural parents - % time ____
- ☐ Natural mother - % time ____
- ☐ Natural Father - % time ____
- ☐ Stepmother - % time ____
- ☐ Stepfather - % time ____
- ☐ Guardian, please specify: ____
- ☐ 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		✓	Rank 0-10	
			ADD (inattentive type)			Thrill seeking (external)
			Inattention (internal)			Competing thoughts; too many thoughts
			Daydreaming			ADHD (Attention Deficit/ Hyperactivity Disorder)
			Poor concentration			Hyperactivity after sugar
			Lack of motivation			Hyperactivity after sedatives
			Impulsivity			Overwhelmed by stimuli
			Distractibility (external)			Hard to make decisions (executive function)
			Stimulus seeking (internal)			Disorganized

SLEEP SYMPTOMS	✓	Rank 0-10		✓	Rank 0-10	
			Night sweats			Restless leg syndrome
			Frequent waking during night (without agitation)			Vivid dreams
			Sleep lightly			Clenching jaw
			Sleeping too much			Waking with agitation
			Sleep apnea			Sleep walking
			Snoring			Sleep talking
			Not rested after sleep			Too busy to sleep (manic)
			Waking early			Teeth grinding
			Physically restless sleep			Night terrors-with screaming, don't remember in morning
			Nightmares (bad dreams)			

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?