Neurofeedback Assessment Questionnaire

Date of Assessment: ____ / ____ / ____

Name:_____ Age:_____Birth Date: ____ / ____ / ____

Address:_____City: _____State:_____ZIP:_____

Phone(s):_____ OK to leave message?_____

Email: _____ OK to email?_____

Gender: M F Handedness: L R Mixed Blood Pressure_____

Briefly describe your presenting problem(s):

It is important to know whether you have any of the following symptoms presently, or have *ever* had them.

ATTENTION SYMPTOMS:

□ ADD (inattentive subtype)
□ Inattention (internal)
□ Daydreaming
□ Poor Concentration
□ Lack of Motivation

□ ADHD (Attention Deficit Hyperactivity Disorder)
□ Hyperactivity after sugar
□ Hyperactivity after sedatives
□ Overwhelmed by stimuli
□ Hard to make decisions (executive function)
□ Disorganized

□ Impulsivity
□ Distractibility
□ Stimulus Seeking
□ Thrill Seeking
□ Competing Thoughts; too many thoughts

Assessment Notes (practitioner):

Name: _____ DOB: ____ / ____ / _____

SLEEP SYMPTOMS:

□ Night sweats
□ Frequent waking during night (without agitation)
□ Sleeping too much
□ Sleep apnea
□ Snoring
□ Not rested after sleep
□ Waking early
□ Difficulty falling asleep (mind quiet)

□ Difficulty falling asleep (mind busy)
□ Hot flashes during sleep
□ Physically restless sleep
□ Nightmares (bad dreams)
□ Bruxism (teeth grinding)
□ Restless leg syndrome
□ Vivid dreams
□ Clenching jaw
□ Waking with agitation
□ "Fox hole" sleep

□ Night terrors, with screaming, doesn't remember in morning
□ Nocturnal myoclonus (jerking, moving while sleeping)
□ Sleep walking
□ Sleep talking
□ Narcolepsy (falling asleep frequently and/or suddenly)
□ Too busy to sleep (manic)
□ Night sweats (hypoglycemic)
□ Enuresis (bedwetting)

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?
Do you dream in color?

Assessment Notes (practitioner):

Name: _____ DOB: ____ / ____ / _____

EMOTIONAL AND BEHAVIORAL SYMPTOMS:

□ Anxiety (Worry)
□ Depression (Helpless and Hopeless)
□ Irritability
□ Feelings easily hurt
□ Perfectionist
□ Remorseful after tantrums
□ Cries easily (feelings hurt)
□ Guilt
□ Withdraws when stressed
□ Passive
□ Wishes was dead
□ Grumpy
□ Thinks little of self
□ Performance Anxiety
□ Shy
□ Seasonal Affective Disorder
□ Fidgets
□ Whining

□ Binge Eating
□ Anorexia
□ Bulimia
□ Bipolar (Manic-Depressive cycles)
□ Panic attacks
□ Encopresis (soiling)
□ IBS (Irritable bowel syndrome)
□ Dissociative Identity Disorder (DID, formerly called Multiple Personality Disorder)
□ Borderline Personality Disorder
□ Post-Traumatic Stress Disorder (PTSD)
□ Rages

□ Anxiety (Fear)
□ Depression (Agitated)
□ Agitation
□ 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
□ Hold a grudge
□ Poor comprehension and expression of emotions
□ Lack of body awareness (pain, discomfort)
□ High pain threshold
□ Loud unmodulated voice
□ Poor eye contact
□ Poor social awareness
□ Autistic symptoms
□ Motor or vocal tics
□ Road rage
□ Nail biting, nervous habits
□ Attachment disorder (history)

Assessment Notes (practitioner):

Name: _____ DOB: ____ / ____ / _____

COGNITIVE SYMPTOMS:

□ 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 visuo-spatial skills
□ 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
□ Don't know left and right

PAIN SYMPTOMS:

□ Chronic pain with depression
□ Chronic aching pain
□ Tension headache
□ Low pain threshold
□ Chronic burning pain
□ Chronic throbbing pain
□ Chronic stabbing pain
□ Chronic shooting pain
□ Sciatica pain
□ High pain threshold
□ Peripheral neuropathy pain
□ Emotional reactivity to pain
□ Fibromyalgia
□ RSD (Reflex Sympathetic Dystrophy)
□ Trigeminal neuralgia
□ Migraine
□ Jaw tension

Assessment Notes (practitioner):
Cursive or printing?
Compare geometry to algebra (spatial/linear to computational, abstract):

Name: _____ DOB: ____ / ____ / _____

NEUROLOGICAL AND MOTOR SYMPTOMS:

□ Left-brain partial seizures
□ Left-brain stroke
□ Left-brain TBI (Traumatic brain injury)
□ Right body paralysis or paresis
□ Enuresis (urinary incontinence)

□ Generalized seizures
□ Absence (petit mal) seizures
□ Tonic-clonic (grand mal) seizures
□ TBI with brain stem injury
□ Vertigo
□ Tinnitus

□ Right-brain partial seizures
□ Right-brain stroke
□ Right-brain TBI
□ Left body paralysis or paresis
□ Spasticity
□ Tremor
□ Poor balance
□ Poor concentration
□ Involuntary regurgitation
□ Tics
□ Nervous habits/laugh
□ Reflux

Assessment Notes (practitioner):

Name: _____ DOB: ____ / ____ / _____

IMMUNE, ENDOCRINE & ANS SYMPTOMS:

□ Sugar craving (hypoglycemia)
□ Immune deficiency
□ Low thyroid function
□ PMS – depressive symptoms
- **□ Irritability**
- **□ Mood swings**
- **□ Insomnia**
- **□ Sugar craving**
- **□ Migraines**
- **□ Pain**
- **□ Cramps**

□ Post-partum depression
□ Intolerant of alcohol, other sedative drugs

□ Hypertension
□ Hypotension
□ Incontinence
□ Severe PMS (mood swings, migraine)
□ Chronic fatigue syndrome
□ Irritable Bowel Syndrome (IBS)
□ Autoimmune disorders:
- **□ Type I diabetes**
- **□ Lupus**
- **□ Rheumatoid Arthritis**
- **□ Crohn's disease**
- **□ Multiple Sclerosis**

□ Asthma
□ Intolerant of coffee, alcohol and many medications
□ Multiple chemical sensitivities

□ Irregular menstrual periods
□ PMS -
- **□ Mania, rage, agitation**
- **□ Racing thoughts**

□ Menopausal hot flashes
□ Skin allergies - eczema
□ Heart palpitations
□ Constipation
□ Intolerant of coffee and other stimulants (agitation)

Assessment Notes (practitioner):

Name: _____ DOB: ____ / ____ / _____

History

Prenatal 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 sever or recurrent illnesses or infections, allergies, emotional difficulties, behavioral problems, appetite/digestion, language/speech, coordination? Walking or talking early? Walking or talking late? History of ear infections? Please describe.

Physical trauma, injury, coma, accidents, high fever, serious illness, surgery, CNS infection, poisoning, anoxia, stroke, heart attack? Have you ever been to the Emergency Room? Please describe.

Recreational drug use? Is so, when, what drugs, and how did each affect you? Have you ever had a drug overdose?

Sensitivity to light such as discomfort with florescent lights, glare, or computer screens? Do things seem too loud?

Psychological stresses/life changes, especially during childhood such as a death, divorce, loss, move, school change, job change, illness? Did you experience 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.

Name: _____ DOB: ____ / ____ / _____

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

Are you currently under treatment or supervision by a health provider? For what condition(s)? Who is your primary health provider?

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.

Have you ever had any neurological or educational testing? Do you have copies of these tests or the results?

Sexual history. History of sexual abuse? History of sexual dysfunction or concerns? Do you have concerns about libido?

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.

Name: _____ DOB: ____ / ____ / _____

Lifestyle Inventory:

Do you drink alcohol? If so, how often? How much?

Do you drink caffeine (soda, tea, coffee, energy drink)? How much? When in the day?

Do you smoke? If so, how many cigarettes per day? How long have you smoked?

Do you like sweets/sugar? (including soda, cereals, etc.)

If yes, how often? What quantity daily?

Do you eat chocolate? How much and how often?

Do you crave salt?

What foods do you favor?

Do you use supplements? If so, for what?

How many hours do you watch TV on weekdays? On weekends?

Do you play computer games? How many hours per week?

Do you read for pleasure?

Do you exercise? What form(s)? How many times a week?

What do you do to relax?

Name: _____ DOB: ____ / ____ / _____

(Practitioner only)

Summarize findings: (including any information from TOVA, QEEG, or other psychometric findings)

Initial indications for left hemisphere training:

Initial indications for placement:

Initial indications for frequency:

Initial indications for right hemisphere training:

Initial indications for placement:

Initial indications for frequency:

Initial indications for interhemispheric training:

Initial indications for placement:

Initial indications for frequency:

Assessment Completed by_____ Date_____