Neurofeedback Assessment Questionnaire

Date of Assessment: _____ / /

Name _____ Age: _____ Birth Date _____ / /

Street Address: _____

City _____ State: _____ Zip: _____

Phone--

Home: _____ Work: _____ Cell: _____

Legal Guardian: _____

School _____ Grade _____

Occupation: _____ How Long? _____

Email _____ Do you check it regularly? Yes No

Sex: M F	Handedness: R L Mixed	Blood Pressure /

Presenting Problem (s):

(It is important to know whether you have any of these symptoms presently, or have ever had them)

ATTENTION SYMPTOMS (Please Check all that apply)

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

	Impulsivity
	Distractibility (external)
	Stimulus Seeking
	Thrill seeking
	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

Assessment notes (practitioner):

Name _____

SLEEP SYMPTOMS

	Night sweats
	Frequent waking during night (without agitation)
	Sleep lightly
	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—w/screaming, doesn't remember in AM
	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 (bed wetting)

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 _____

EMOTIONAL AND BEHAVIORAL SYMPTOMS

	Anxiety (Worry)
	Depression (Helpless & 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

	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)

	Binge Eating
	Anorexia
	Bulimia
	Bipolar (Manic-depressive cycles)
	Panic attacks
	Encopresis (soiling)
	IBS (Irritable Bowel Syndrome)
	Dissociative Identity Disorder (Multiple Personality)
	Borderline Personality Disorder
	Post-Traumatic Stress Disorder (PTSD
	Rages

Name_____

Assessment notes (practitioner):

Name _____

COGNITIVE SYMPTOMS

	Dyslexia		Non-verbal learning disabilities
	Poor word fluency		Poor visual-spatial skills
	Poor sequential processing		Poor sense of self in space
	Poor sequential planning		Poor drawing
	Poor reading comprehension		Inability to write neatly(even slowly)
	Difficulty decoding words		Poor fine motor skills
	Poor arithmetic calculation		Poor math concepts
	Indecisive		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 burning pain
	Chronic aching pain		Chronic throbbing pain
	Tension headache		Chronic stabbing pain
	Low pain threshold		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 _____

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)

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

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

Assessment notes (practitioner):

Name _____

IMMUNE, ENDOCRINE & ANS SYMPTOMS

	Sugar craving (hypoglycemia)		Irregular menstrual periods
	Immune deficiency		PMS –
	Low thyroid function		Mania, rage, agitation
	PMS - depressive symptoms		Racing thoughts
	Irritability		Menopausal hot flashes
	Mood swings		Skin allergies - eczema
	Insomnia		Heart palpitations
	Sugar craving		Constipation
	Migraines		Intolerant of coffee and other stimulants (agitation)
	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
	Autoimmune disorders:
	Type I diabetes
	Lupus
	Rheumatoid Arthritis
	Crohn's disease
	Multiple Sclerosis
	Asthma
	Intolerant of coffee, alcohol and many medications
	Multiple chemical sensitivities

Assessment notes (practitioner):

Name _____

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 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? If so, when, what drugs and how did each effect 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 _____

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

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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? Do you have concerns about libido?

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

Name _____

Lifestyle inventory:

Do you drink alcohol?	If so, how often?	How much?
Do you drink caffeine (soda, tea, coffee)?	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? (Remember hidden sugars in soda, cereals, processed products, 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 a week?

Do you read for pleasure? _____

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

What do you do to relax? _____

Name _____

(Practitioner only)

Summarize findings: (include 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 frequency:

Initial indications for placement:

Assessment completed by_____
Date _____