Biofeedback and Family Therapy Center
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Neurofeedback / Biofeedback Intake Questionnaire

Adult clients please fill out for yourself. Parents, please fill out for your child. Some questions may not apply. Simply do your best as the more information we can collect the more effective your assessment and treatment will be. Please use the back of the page if you need more room. All information is confidential and becomes part of your HIPPA-protected patient file. Thank you!

PERSONAL INFORMATION:

Patient Name: _____ Gender: _____ D.O.B. ___/___/_____Age: _____ L or R Handed? ____ Date: _____

Why are you coming for help now?

_____

_____

What helps the most in coping with this? _____

_____

Briefly list other approaches you have tried (e.g. medication, behavior therapy, counseling, alternative medicine:

_____

_____

What (if anything) makes it worse?

_____

_____

What benefits do you hope to gain from Neurofeedback/Biofeedback?

_____

GENERAL HEALTH INFORMATION

1. **OVERALL HEALTH:**

   How would you rate your current health? (1 = the worst & 10 = the best) 1 2 3 4 5 6 7 8 9 10
   How would you rate your current diet? (1 = the worst & 10 = the best) 1 2 3 4 5 6 7 8 9 10

2. **ACTIVITY LEVEL:** Please check one.

   ___ Sedentary (No exercise)
   ___ Mild exercise (i.e., climb stairs, walk 3 blocks, golf, plays quietly, many hours daily playing video games, watching TV or on the computer)
   ___ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
   ___ Regular vigorous exercise (i.e., work or recreation 4-5x/week for 30 minutes)

3. **SLEEP QUANTITY & QUALITY:**

   Average bedtime _____ AM/PM How long on average does it take you to fall asleep? _____
   Average rising time _____ AM/PM Average hours of sleep weekday?_____ Average hours of sleep weekend/holiday? _____
   Fall asleep easily most nights? Y / N
   Wake refreshed? Y / N
   Sleeping too much? Y / N
   Sleeping too little? Y / N

Sleep apnea? Is it being treated? Y / N explain:

Excessive daytime sleepiness? Y / N / explain:

Rate the quality of sleep you usually get (over the last month) (1 = the worst to 10 = the best) 1 2 3 4 5 6 7 8 9 10

4. SLEEP PROBLEMS:

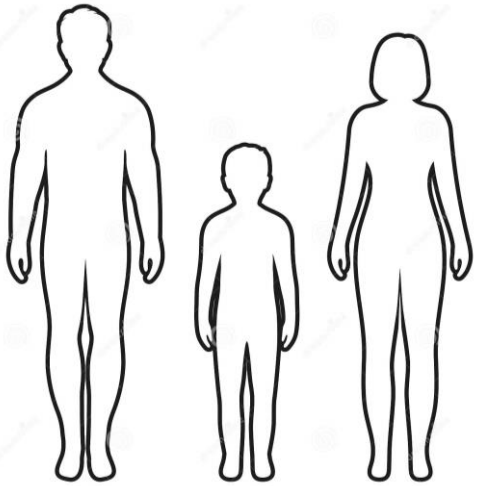
Frequent waking?	Y / N, If Yes describe:
Night sweats?	Y / N, If Yes describe:
Snoring?	Y / N, If Yes describe:
Frequent nightmares?	Y / N, If Yes describe:
Restless sleep?	Y / N, If Yes describe:
Bed wetting?	Y / N, If Yes describe:
Restless leg syndrome?	Y / N, If Yes describe:
Vivid dreams?	Y / N, If Yes describe:
Clenching jaw/teeth grinding?	Y / N, If Yes describe:
Waking with agitation/anxiety?	Y / N, If Yes describe:
Sleep walking?	Y / N, If Yes describe:
Sleep talking?	Y / N, If Yes describe:
Night terrors with screaming?	Y / N, If Yes describe:
Sleep paralysis?	Y / N, If Yes describe:
Do you wake anxious?	Y / N, If Yes describe:

5. CHRONIC HEALTH PROBLEMS OR CHRONIC PAIN? Please briefly describe:

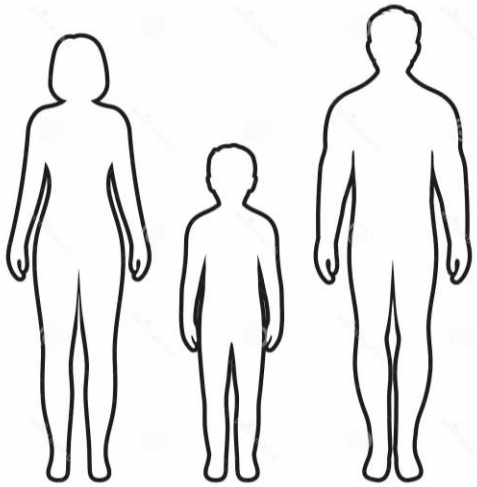
_____

_____

Please mark the area(s) of the body affected, use a smaller x for mild a medium x for moderate and a large x for severe. Label type of pain (sharp, dull, aching, throbbing, deep, surface, constant, intermittent).



FRONT or SIDE



BACK

6. MENTAL HEALTH: How would you describe your general emotional state? (a brief sentence or short phrase is fine):

_____

Are you currently working with a psychiatrist, therapist, counselor or clergy in matters regarding your mental health? Y / N
If yes, please list name(s), if you have a diagnosis or diagnoses and what they are:

_____

7. HORMONES: Are you concerned that hormonal imbalances may be contributing to your condition? Have you had your thyroid function tested? Y / N, if Yes please explain:

_____

8. ALLERGIES/TOXIC EXPOSURE:

Any allergies, chemical sensitivities (incl. to medication)? Y / N, If Yes, please describe & include symptoms.

_____

Ever exposed to toxic agents? (e.g. heavy metals, lead, pesticides, carbon monoxide, solvents, mold?) please explain:

_____

9. NEUROLOGICAL:

Are you or have you ever been sensitive to lights or strobe lights? Y /N, If Yes please describe:

_____

Have you had or been diagnosed with migraines or epileptic seizures? Y /N, If Yes please describe:

_____

Do you meditate? Practice self-hynosis? Use relaxation audio or other similar practices? Please describe:

_____

10. SUBSTANCES:

Do you **currently** use psychoactive drugs, non-prescribed medications or alcohol to pick yourself up or calm yourself down?
Y /N, If Yes please describe type/quantity/frequency:

_____

In the past, have you used psychoactive drugs, non-prescribed medications or alcohol to pick yourself up or calm yourself down?
Y /N, If Yes please describe type/quantity/frequency:

_____

Psychedelics (also known as hallucinogens) are a class of psychoactive substances that produce changes in perception, mood and cognitive processes. If you have used these substances have you experienced any of the following **either negative or positive** during use or afterwards:

____ hallucinations, what/when? _____

____ visual flashbacks (days, weeks or years later) what/when? _____

____ emotional flashbacks (days, weeks or years later) what/when? _____

____ somatic/body sensation flashbacks (days, weeks or years later) what/when? _____

____ other experiences/changes _____

Do you smoke or vape tobacco products? Y /N, If Yes please describe type/amount/frequency:

_____

Do you use caffeine? Y /N, If Yes please please describe type/amount/frequency:

_____

Do you consider your use of any of the above to be a problem now or in the past? Y /N, If Yes please discuss:

_____

Have you ever experienced blackouts or lost time due to alcohol or substance use? Y /N, If Yes please discuss:

_____

11. MEDICATIONS & SUPPLEMENTS:

Please list any current or recent (last 1-3 yrs) MD or RN prescribed medications, drugs, hormone replacements, allergy/asthma treatments, alternative therapies, nasal sprays, COVID treatments etc. Also include dosage/frequency/time of day taken and what it is prescribed for.

Medication Name	***Dosage***	***Frequency and Time (AM, Noon, PM, Bedtime)***	***Used For?***
OTC Meds, Herbals, Vitamins Names	***Dosage***	***Frequency and Time (AM, Noon, PM, Bedtime)***	***Used For?***

HISTORY

12. CHILDHOOD / DEVELOPMENTAL HISTORY:

Significant psychological stresses/life changes especially during childhood such as a death, divorce, loss, family illness, move/relocation stress, violence/war trauma. Any emotional, physical or sexual abuse or neglect? Please describe:

_____

_____

Problems with growth and development caused by illness, infection, allergies, emotional/behavioral issues, appetite/digestion, language/speech, coordination? Walking or talking early or late? Developmental milestones hit? Problems with sensory integration? History of excessive ear infections? Please describe:

_____

_____

Problems with social interactions, making & keeping friends etc?

_____

13. PREVIOUS TESTING or NEUROFEEDBACK? Any neurological testing or previous Neurofeedback? Do you have copies of these tests or results? If Y, please describe: _____

14. EDUCATIONAL HISTORY:

Any history of learning difficulties? Y/N Describe:

_____

Any history of memory problems? Y/N Describe:

_____

Have you/your child been diagnosed with ADD/ADHD? Y/N, when diagnosed?_____, by whom? _____

Were medications tried? Which ones? Were they helpful?

_____

Any educational therapies? (tutors, special schools, IEP's etc.)? Y /N, If Yes please describe

_____

How well do you/your child function at school or work?

_____

15. HISTORY OF HEAD, NECK or BRAIN INJURY:

Have you ever injured your head or neck?	Yes	No
Have you ever had a concussion?	Yes	No
Have you ever lost consciousness?	Yes	No
Have you ever had a stroke?	Yes	No
Have you ever had another kind of TBI (traumatic brain injury?)	Yes	No
Have you had head, neck or brain surgery?	Yes	No
Any CNS (Central Nervous System) Infection such as encephalitis?	Yes	No
If Yes to any of the above, how many times?	#? _____	
Are you currently receiving care for any of these injuries?	Yes	No

Thinking back over the years, please describe your **head or neck injuries**. You may continue on the reverse side of this page if necessary . (Please consider the childhood & teen years as well as adulthood, including home life, sports, accidents, slip/falls & any incidents of violence. Give approximate age at which the injury occurred).

_____

16. OTHER <u>NON-HEAD/NECK</u> INJURY or TRAUMA:

Looking back over the lifespan, please note any of the following and if yes, briefly describe.
Use the reverse side of the page if you need more room.

Physical Trauma Yes / No Date or Age: Desc: _____

Other Trauma Yes / No Date or Age: Desc: _____

Major Injury	Yes / No	Date or Age:	Desc:_____
Coma	Yes / No	Date or Age:	Desc: _____
Accident	Yes / No	Date or Age:	Desc: _____
High Fever	Yes / No	Date or Age:	Desc: _____
Serious Illness	Yes / No	Date or Age:	Desc: _____
Surgeries	Yes / No	Date or Age:	Desc: _____
Poison/Overdose	Yes / No	Date or Age:	Desc: _____
Anoxia (low oxygen)	Yes / No	Date or Age:	Desc: _____
Heart Attack	Yes / No	Date or Age:	Desc: _____
COVID-19	Yes / No	Date or Age:	Desc: _____
Partner Abuse	Yes / No	Date or Age:	Desc: _____

Have you/your child ever taken to the Emergency Room? Yes / No , please explain:

_____

17. EMOTIONAL / BEHAVIORAL HISTORY:

In the past, have you/your child ever been diagnosed with an anxiety disorder, depressive disorder, schizophrenia, bipolar disorder (AKA manic depression), autism/Asperger's, alcohol or substance use disorders, a developmental disorder or dementia? Y/N, details?

_____

Have you taken psychiatric medications in the past for any of these conditions? Y /N Please provide details:

_____

Any family history of the above conditions or other mental health conditions? Y / N, please describe:

_____

18. SYMPTOM CHECKLIST: Check any significant symptoms you/your child are experiencing or have experienced in the past. Please scale 0 -10 (0=no problem to 10 = a high level of problem/difficulty)

EMOTIONAL & BEHAVIORAL:

___ _____ Anxiety or Panic
___ _____ Depressed mood
___ _____ Sadness/Crying Spells
___ _____ Feelings easily hurt
___ _____ Perfectionist
___ _____ Rages, Excessive anger
___ _____ Cries easily
___ _____ Guilt
___ _____ Nervousness/Jittery
___ _____ Withdraws when stressed
___ _____ Passive
___ _____ PTSD
___ _____ Socially Isolated
___ _____ Difficulty Having Fun
___ _____ Grumpy
___ _____ Low Self-esteem
___ _____ Shy, Social anxiety
___ _____ Whiny
___ _____ Loud
___ _____ Poor eye contact
___ _____ Poor social awareness
___ _____ Motor or Vocal Tics
___ _____ Nail-biting, hair pulling]
___ _____ Performance anxiety
___ _____ Impatient
___ _____ Rumination
___ _____ Obsessions/Compulsions
___ _____ Excessive worry
___ _____ Mood Swings
___ _____ Problems with food
___ _____ Recent weight loss/gain
___ _____ Lacks empathy
___ _____ High need for control
___ _____ Difficulty w/emotions
___ _____ Holds grudges
___ _____ Suicidal behaviors
___ _____ Suicidal thoughts
___ _____ Argumentative
___ _____ Conflicts with peers
___ _____ Difficulty with authority

ATTENTIONAL/HYPERACTIVITY:

___ _____ Inattentive to detail
___ _____ Daydreaming
___ _____ Poor concentration
___ _____ Lack of motivation
___ _____ Impulsive
___ _____ Distractible
___ _____ Stimulus seeking
___ _____ Thrill seeking
___ _____ Always active
___ _____ Racing/too many thoughts
___ _____ Hyperactivity after sugar
___ _____ Hyperactivity after sedatives
___ _____ Overwhelmed by stimuli
___ _____ Difficulty sitting still
___ _____ Restless legs
___ _____ Very sensitive to rejection
___ _____ Gives up easily

COGNITIVE:

___ _____ Dyslexia
___ _____ Difficulty w/ decisions
___ _____ Disorganized
___ _____ Difficulty making plans
___ _____ Difficulty prioritizing
___ _____ Loses things a lot
___ _____ Knowing Right from Left
___ _____ Monotone or unusual speech
___ _____ Poor fine motor skills
___ _____ Problems with math skills
___ _____ Problems with reading or writing skills
___ _____ Difficulty following directions
___ _____ Problems with memory

SENSORY INTEGRATION:

___ _____ Bothered by clothing tags?
___ _____ Bothered by the feeling of certain textures incl food?
___ _____ Unusually sensitive to certain smells?
___ _____ Unusually sensitive to certain sounds?
___ _____ Unusually sensitive to the environment?
___ _____ Are you clumsy or accident prone?

OTHER NEUROLOGICAL:

___ _____ Vertigo
___ _____ Tremors
___ _____ Poor balance
___ _____ Poor coordination
___ _____ Tinnitus
___ _____ Misophonia
___ _____ Nervous habits

SYMPTOMS (cont)
Of the issues identified above, list the 4 most severe ones, age they began, days per week they occur, severity 1-10 and any other info you'd like us to know)

Symptom	Age or year began?	How often?	Severity (a range is fine)	Other Info / Explanation:
1.				
2				
3.				
4.				

19. ADJUSTMENT:

In the last year have you experienced any significant life events, changes or situations to which you have had to adjust? Examples might include but not be limited to: deaths, births, marriages, divorces, infidelity, separations, interactions with the legal system, being a victim of crime, starting or ending being the primary caregiver for a friend/family member, other family/work/career/financial changes etc.? Please describe briefly.

In the next 1-2 years do you expect any of these life events listed above/or others? Please describe briefly.

THANK YOU!