TotalHealth
NUTRITION CENTER

Neurofeedback Survey

PERSONAL INFORMATION

Name_____ Date of birth_____ Age _____

Address_____

City State Zip _____

Home/Cell Phone _____ Work Phone _____

Email address _____

Occupation _____ Gender **M** **F**

Emergency contact/relationship/telephone # _____

Tell us more about your needs and desires regarding brain health. How can we help? What are you hoping to address or achieve through our Neurofeedback Program?

_____

HEALTH INFORMATION

1. OVERALL HEALTH	**Answer**
On a scale of 1-10, how would you rate your current health?(1 = worst, 5 = average, 10 = best)	
2. SLEEP	**Answer**
Rate the quality of sleep you usually get (eg., past month) (1 = worst, 5 = average, 10 = best)	
At what time do you go to bed?	
At what time do you rise in the morning?	
Are you able to sleep through the night?	
If no, please describe.	
Are you able to fall asleep easily most nights?	
If no, please describe.	
Do you wake refreshed?	
If yes, please describe any exceptions.	
3. HEAD OR NECK INJURY	**Answer**
Have you ever injured your head or neck?	
Ever had a concussion?	
If yes, have you suffered more than one concussion?	
Have you ever been in an auto, motorcycle or bicycle accident?	
Have you ever had a traumatic brain injury?	
Are you currently receiving care for this/these injuries? (explain)	

3. HEAD or NECK INJURY(cont'd)	
Please describe your head or neck injuries using the reverse side of this page, thinking back over the years. Please consider the childhood and teen years, as well as adulthood, including home life, sports, accidents, slips/falls, etc.	
4. CHRONIC HEALTH PROBLEMS?	
Please list any chronic medical problems or brain health issues you have on the back side of this form.	
5. HORMONES	**Answer**
Are you concerned that hormonal imbalances that may be contributing to your condition?	
6. MOODS & EMOTIONS	
How would you describe your general emotional state? (A brief sentence or short phrase of 3-4 words is fine.)	
7. MEDICATIONS, SUPPLEMENTS & VITAMINS	
Please provide a list here including name, dose, frequency and for what symptom you are taking each. Feel free to attach a supplement list.	
Any known medication allergies? Please list.	
8. SUBSTANCES	**Answer**
Do you ***currently*** use psychoactive drugs, medications or alcohol to pick yourself up or calm yourself down?	
Have you ever used psychoactive drugs, medications or alcohol ***in the past*** to pick yourself up or calm yourself?	
Are you currently a smoker?	
Do you consider your current use of tobacco, alcohol or street drugs a problem?	
If yes on any of these substances, list those currently taking.	
Do you feel depressed or anxious at the present time?	
Have you suffered from depression or anxiety in the past?	
9. ATTENTION & LEARNING	**Answer**
Any history of learning difficulties?	
Any history of memory problems?	
Any history of ADD/ADHD?	
In childhood? Adulthood? (please circle)	
10. OTHER CONDITIONS	**Answer**
Any history of other psychiatric conditions in yourself, such as schizophrenia, bi-polar disorder, psychosis?	
Any history of other psychiatric conditions in family members, such as schizophrenia, bi-polar, psychosis?	
11. COUNSELING & PSYCHOTHERAPY	**Answer**
Are you currently working with a psychiatrist, therapist, counselor or clergy in matters regarding your mental health?	
If yes, please list name/names, telephone and emails.	

12. SEIZURES OR LIGHT SENSITIVITY?	Answer
Are you, or have you ever been, sensitive to lights or strobe lights, had or been diagnosed with migraines or epileptic seizures?	
13. Is there anything that you would like to add?	

Parent or Guardian of Minor, please complete this section

Parent/Guardian Name _____

Address City State Zip _____

Telephone_____ Email _____

Do you live with the client? Y N

Informed Consent Form

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Total Health Nutrition Center offers Neurofeedback (NFB) training for conditions associated with irregular brain and nervous system activity. Conditions may include ADD/ADHD, insomnia, anxiety, depression, chronic pain, addiction disorders and more.

NFB is a type of biofeedback training that teaches the client self-regulation of brain function. The NFB system uses computer technology to stimulate the brain through sound, light, visual contrasts and color. The NFB system closely monitors brain wave activity for abnormal or irregular brain wave patterns. When detected, the system produces a signal that helps guide the irregular brain wave pattern(s) into healthy patterns. Sensors are attached to the ear lobes and sections of the scalp to be monitored - as determined by the client's brain map analysis. **Nothing is done to the client's brain.** The sensors simply monitor how the brain is reacting to the training and the computer technology only provides suggestions, but ultimately the brain decides what it wants to learn. As such, NFB cannot make any guarantees.

Research has been conducted to study the effects of NFB and these studies have been published in peer reviewed, professional journals relevant to this field of study. Extensive research and clinical experience have demonstrated the effectiveness of NFB for a wide variety of conditions.

NFB training is considered particularly safe and is generally without harmful side effects. However, any intervention that can lead to positive results can also lead to unwanted effects, especially in the beginning of one's training sessions. Because this is a training approach, both desirable and undesirable effects such as headaches, fatigue and irritability may occur. If this does occur, please inform the practitioner and the necessary adjustments will be made.

Also please be aware that certain things can impede one's improvement with NFB and training may take longer than the recommended 20 sessions. These things include a poor diet, stressful lifestyle (i.e. toxic relationships, poor home situation, strong dislike of job/school, abuse, etc.) and brain injuries. In addition, as we age, our brains become more ridged therefore training may take longer for people over 50 years of age.

Our practitioners have a minimum of 2 years of clinical and research experience in NFB. They participate in ongoing training, education and interaction with neuroscientists from our training company, Clearmind. However, Total Health Nutrition Center makes no claims or guarantees of a specific or anticipated outcome. **NFB only provides suggestions to the brain, but ultimately the brain decides what it wants to learn.**

I have read and understood this document.

Signed:_____ **Date:**_____

Total Health
NUTRITION CENTER
N82 W15485 Appleton Ave.
Menomonee Falls, WI 53051
www.totalhealthinc.com

Name: _____ **Date:** _____

Please use the key below to rate your symptoms. If the symptom does not apply to you, leave it blank. This tool will provide valuable information for us about how well your brain will learn during the training sessions.

Severity	Frequency
A=Unbearable	0= Never
B= Very Unpleasant	1= Rarely
C=Unpleasant	2=Sometimes
D=Mild	3= Often
E=Very Mild	4= Very Often
F=Nothing	5= All Of The Time

SYMPTOM	SEVERITY	FREQUENCY
ABDOMINAL BLOATING		
HEADACHES		
ABDOMINAL PAIN		
HEART PALPITATIONS		
INSOMNIA		
STOMACH PAINS		
JOINT PAIN		
LUMP IN THROAT		
HEART RACING		
BACK PAIN		

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E=Very Mild	4= Very Often
F=Nothing	5= All Of The Time

SYMPTOM	SEVERITY	FREQUENCY
MENSTRUAL IRREGULARITY		
BULIMIA		
NAUSEA		
EXCESS SWEATING		
CONSTIPATION		
DIARRHEA		
RINGING IN THE EARS		
DIZZINESS		
SEXUAL INDIFFERENCE		
SHAKING OR TREMOR		
NUMBNESS		
SPASMS		
SHOCK SENSATION		
SUDDEN WEIGHT FLUCTUATION		
TINGLING		
TICS-VERBAL OR MOTOR		
DRYMOUTH		
DYSURIA (PAINFUL URINATION)		

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SYMPTOM	SEVERITY	FREQUENCY
EXCESSIVE MENSTRUAL BLEEDING		
RESTLESS LEGS		
EXTREMITY PAIN		
FAINTING SPELLS		
VISUAL BLURRING		
FATIGUE		
VOMITING		
FOOD INTOLERANCES		
FRIGIDITY (ABSENCE OF ORGASM)		
WEAKNESS		
WEIGHT LOSS		
HEARTBURN		
INDIGESTION		
ITCHY SKIN		
YELLOWISH EYES		
GREASY FOOD DISTRESS		

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SYMPTOM	SEVERITY	FREQUENCY
REDDENED SKIN		
TREMBLING		
MUSCLE ACHES & PAINS		
EXCESSIVE THIRST		
HIGH BLOOD PRESSURE		
SLEEPINESS		
DARK URINE		
LIGHT COLORED STOOLS		
CHEST PAINS		
LABORED BREATHING		
SHORTNESS OF BREATH		
GENERALIZED ITCHING		
LOSS OF APPETITE		
DRY OR FLAKY SKIN		
AGITATION		
IRRITABLE WITH MISSED MEALS		

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E=Very Mild	4= Very Often
F=Nothing	5= All Of The Time

SYMPTOM	SEVERITY	FREQUENCY
CRAVE SWEETS		
EATING RELIEVES FATIGUE		
CAFFEINE DEPENDENT		
NON-RESTORATIVE SLEEP		
COLD ALL THE TIME		
WEIGHT GAIN		
MORNING HEADACHES		
HAIR THINNING		
NIGHT SWEATS		
DIFFICULTY GAINING WEIGHT		