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?

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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