Neurofeedback/qEEG Intake/History

Name of client: _____ Age: _____ DOB: _____
Address:_____ City/State/Zip code:_____
Phone: (Cell) _____ (Home) _____ (Work) _____

Parent(s) or Guardian (s) of minor:
Name(s): _____

Physician/other healthcare professional:
Name: _____ Phone: _____
Diagnosis: _____
Current medications: _____

What benefits do you hope to gain from neurofeedback/qEEG?: _____
_____
_____
_____

Developmental History: Please indicate you (or your child's) history in relation to the following:

Prenatal and Birth	Yes	No	Details
Prenatal stress or injury	____	____	_____
Prenatal drug/alcohol exposure	____	____	_____
Birth trauma (forceps, breech, etc.)	____	____	_____
Anesthesia, pain medications	____	____	_____
Anoxia (oxygen deprivation at birth)	____	____	_____
Premature/late delivery	____	____	_____
Medical problems after birth	____	____	_____
Birth weight _____	Adopted age ___		Other _____

Growth and Development	Typical	More	Less	Details
Activity Level	____	____	____	_____
Motor/coordination development	____	____	____	_____
Infections/allergies	____	____	____	_____
Emotional development	____	____	____	_____
Behavior concerns	____	____	____	_____
Handedness development	____	____	____	_____
Appetite/digestion	____	____	____	_____
Language/speech development	____	____	____	_____

Physical Trauma	Yes	No	Details
Head injury (even minor falls, etc.)	____	____	_____

Coma (loss of consciousness)	____	____	_____
Accidents (list all)	____	____	_____
High Fever	____	____	_____
Serious illness	____	____	_____
Surgery	____	____	_____
CNS infection	____	____	_____
Drug overdose/poisoning	____	____	_____
Recreational drug use	____	____	_____
Anoxia	____	____	_____
Stroke	____	____	_____

Psychological stress/Life Changes	Yes	No	Details
Death in family	____	____	_____
Divorce/Remarriage	____	____	_____
Move/relocation	____	____	_____
School change	____	____	_____
Job change	____	____	_____
Family member chronic illness	____	____	_____

Symptom Checklist: Please indicate if you (client) or a family member currently experiences or has a history of any of the following symptoms.

Symptom	X if client	X if family	X if current
Feeling tense	_____	_____	_____
Depressed	_____	_____	_____
Always on the go	_____	_____	_____
School/work problem	_____	_____	_____
Impulsivity	_____	_____	_____
Hyperactivity	_____	_____	_____
Attention problems	_____	_____	_____
Behavior problems	_____	_____	_____
Vocal or motor tics	_____	_____	_____
Sleep problems	_____	_____	_____
Legal trouble	_____	_____	_____
Headaches	_____	_____	_____
Feeling lonely	_____	_____	_____
Frequent illness	_____	_____	_____
Repetitive thoughts	_____	_____	_____
Repetitive behavior	_____	_____	_____
Shy with people	_____	_____	_____
Allergies	_____	_____	_____
Asthma	_____	_____	_____
Seizures/epilepsy	_____	_____	_____
Chronic pain	_____	_____	_____

Food sensitivity	_____	_____	_____
Head injury	_____	_____	_____
Memory problems	_____	_____	_____
Temper tantrums	_____	_____	_____
Rages	_____	_____	_____
Verbal aggression	_____	_____	_____
Stubbornness	_____	_____	_____
Addictions	_____	_____	_____
Bowel disturbances	_____	_____	_____
Chronic fatigue/FMS	_____	_____	_____
Inferiority feelings	_____	_____	_____
Dizziness	_____	_____	_____
Fainting spells	_____	_____	_____
Heart palpitations	_____	_____	_____
Stomach trouble	_____	_____	_____
Poor appetite	_____	_____	_____
Picky eater	_____	_____	_____
Nightmares	_____	_____	_____
Alcohol/drug problem	_____	_____	_____
Feeling panicky	_____	_____	_____
Tremors	_____	_____	_____
Suicidal ideas	_____	_____	_____
PMS	_____	_____	_____
Physical/sexual abuse	_____	_____	_____
Over-ambitious	_____	_____	_____
Unable to relax	_____	_____	_____
Can’t make decisions	_____	_____	_____
Communication problems	_____	_____	_____
Problems at home	_____	_____	_____
Financial problems	_____	_____	_____
Any chronic illness	_____	_____	_____
Other, specify	_____	_____	_____

Please circle the five current problem listed above that are most distressing to you or your child.