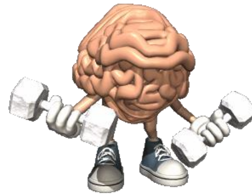


Brain Solutions Plus+

61 W. Jordan Street

Brevard, NV 28712

Intake Questionnaire

Date: _________________

PATIENT INFORMATION

Patient Name	Age	DOB
Address		
City/State/Zip		
Phone (home)	Cell	

PARENT(S) OR GUARDIAN(S) OF MINOR

Patient Name	Age	DOB
Address		
City/State/Zip		
Phone (home)	Cell	

PLEASE DESCRIBE YOUR COMPLAINTS (WHY YOU ARE HERE)

WHAT BENEFITS DO YOU HOPE TO GAIN FROM NEUROFEEDBACK TRAINING?

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

	ADD		SEIZURE DISORDERS SUCH AS EPILEPSY		ALZHEIMER'S
	ADHD		DEPRESSION		COGNITIVE IMPAIRMENT
	TRAUMATIC BRAIN INJURY		BIPOLAR DISORDER		STROKE OR TRANSIENT ISCHEMIA
	ANXIETY		TOURETTE'S		POST TRAUMATIC STRESS DISORDER
	SLEEP DISORDER		MIGRAINES		ASTHMA
	IRRITABLE BOWEL		ALLERGIES		CHRONIC PAIN
	HEART ATTACK		HEART DISEASE		OBSESSIVE COMPUSLIVE DISORDER
	FIRBOMYALGIA		REFLEX SYMPATHETIC DYSTROPHY (RSD)		HIGH BLOOD PRESSURE

Please indicate any other pertinent diagnosis that is not listed above:

WHO DIAGNOSIS YOUR CONDITION(S) AND WHAT IS THEIR PROFESSION?

NAME	PROFESSION	CONDITION DIAGNOSED

PLEASE LIST ALL MEDICATIONS, WHO PRESCRIBED AND FOR WHAT CONDITION

MEDICATION	DOCTOR THAT PRESCRIBED	CONDITION TAKEN FOR

PATIENT NAME ____ DATE ___________________________

SLEEP SYMPTOMS

	DIFFICULTY GOING TO BED		RESTLESS LEG
	DIFFICULTY GOING TO SLEEP		BED WETTING OR SOILING
	WAKE UP FREQUENTLY		NIGHTMARES
	EARLY AWAKENING		SLEEP TO MUCH
	RESTLESS SLEEP		SLEEP APNEA
	TALKING IN SLEEP		BRUXISM (teeth grinding)
	WALKING IN SLEEP		VIVID DREAMS
	NIGHT TERRORS		NIGHT SWEATS

COGNITIVE SYMPTOMS

	DYSLEXIA		POOR VISUAL SPATIAL SKILLS
	POOR WORD FLUENCY		POOR SENSE OF SELF IN SPACE
	POOR ABILITY TO PROCESS		INABILITY TO WRITE NEATLY
	POOR ABILITY TO PLAN		POOR FINE MOTOR SKILLS
	POOR READING COMPREHENSION		POOR SPELLING
	DIFFICULTY UNDERSTANDING WORDS		POOR SENSE OF DIRECTION
	POOR ARITHMETIC SKILLS		POOR TRACKING DURING READING
	INDECISIVE		POOR MEMORY

PAIN SYMPTOMS

	CHRONIC PAIN WITH DEPRESSION		CHRONIC THROBBING PAIN
	CHRONIC ACHING PAIN		CHRONIC STABBING PAIN
	TENSION HEADACHE		CHRONIC SHOOTING PAIN
	LOW PAIN TOLERANCE		SCIATICA PAIN
	FIBROMYALGIA		HIGH PAIN TOLERANCE
	MIGRAINE		PERIPHERIAL NEUROPATHY PAIN
	JAW TENSION		EMOTIONAL REACTIVITY PAIN
	CHRONIC BURING PAIN		PAIN IN THE SHOULDERS AND NECK

PATIENT NAME ____ DATE _____________________________

IF YOU ARE EXPERIENCING PAIN, NUMBNESS, TINGLING, AND/OR BURNING SENSATIONS, THEN PLEASE COMPLETE THE DIAGRAM BELOW:

Please mark off the areas of your complaint on the diagrams to the right with the following indicators:

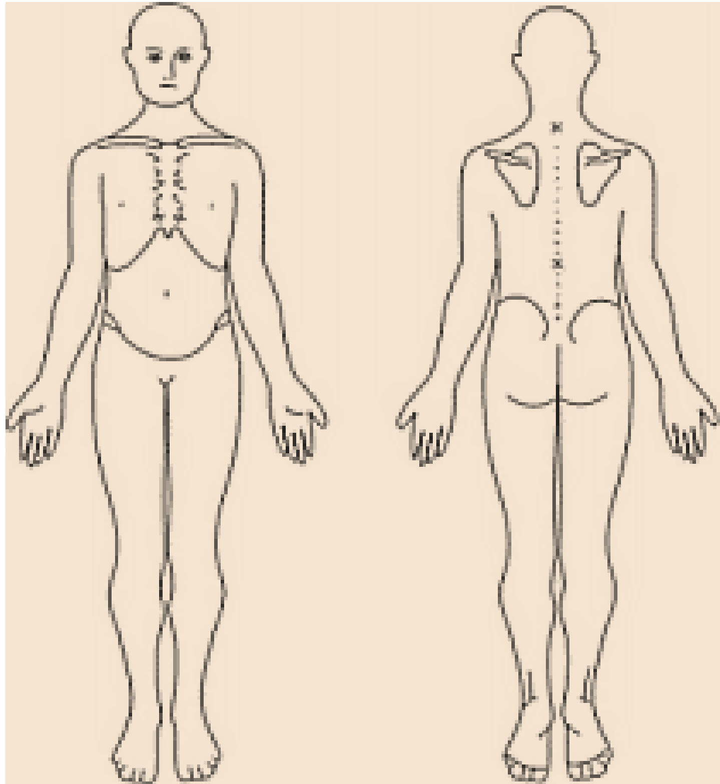
PPP = pain

NNN= numbness

TTT= tingling

BBB=burning

CCC=cramping



PLEASE LIST FIVE GOALS THAT YOU HOPE TO ACHIEVE WITH NEUROFEEDBACK

1.
2.
3.
4.
5.

PATIENT NAME ____ DATE __________________________

INFORMED CONSENT

PATIENT NAME ____ DATE ___________________________

Neurofeedback training is a process of providing information to the client about the nervous system, and brainwave activity. To gather the information necessary for a feedback program, sensors are attached to the scalp.

Nothing is done to the client. The sensors simply measure changes in the system monitored. The information is seen on a computer screen and heard through speakers or headphones. The clients is able to see and hear changes in physiological activity and, by practicing self-regulation techniques such as relaxation and breathing, the client can learn to correct imbalances in the systems being monitored. This process may result in improvement in the client's presenting condition(s) as these functional problems are corrected.

Research has been conducted to study the effects of this intervention 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 eeg-biofeedback interventions for a wide variety of conditions.

These interventions are considered particularly safe and generally without harmful side-effects. However, any intervention that can lead to positive results can also lead to unwanted effects. Because this is a training approach, both desirable and undesirable effects continue for only a short tie unless they are reinforced. This characteristic helps limit the potential for lasting negative effects and allows for selective reinforcement of positive effects.

Neurofeedback of Brevard makes no claim or guarantee that this training will be effective for your specific concerns. All client records and transactions are confidential unless release of these records is authorized in writing by the client, or otherwise required by law. Clients will have access to their records. Other services may also be effective for a client's condition(s). Information about such services will be provided upon request. Clients have the right to choose freely among available practitioners and to change practitioners after services have begun. The client can expect a coordinated transfer if he/she changes service providers. Clients may refuse any service training approach. Clients may freely assert any of these rights.

I have read and understand this document and I have had the opportunity to ask questions and have had those questions answered to my satisfaction.

Signed: ____ Date: _______________________________

Witness: ____ Date: _______________________________

ADULT SELF REPORT SCALE: SYMPTOM CHECKLIST

Patients Name: ____ Date: __________________________

Please answer all of the questions below, rating yourself in each of the criteria shown using the scale on the right side of the page. As you answer each question, circle the correct number that best describes how you have felt and conducted yourself over the past six months.		Never	Rarely	Sometimes	Often	Very Often	Score
1.	How often do you make careless mistakes when you have to work on boring of difficult projects??						
2.	How often do you have difficulty keeping your attention when you are doing boring or repetitive work?						
3.	How often do you have difficulty concentrating on what people say to you, even when they are speaking directly to you?						
4.	How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?						
5.	How often do you have difficulty getting things in order when you have to do a task which requires reorganization?						
6.	When you have a task that requires a lot of thought, how often do you avoid or delay getting started?						
7.	How often do you misplace or have difficulty finding things at home or at work?						
8.	How often are you distracted by activity or noise around you?						
9.	How often do you have problems remembering appointments or obligations?						
	PART A SCORE						
10.	How often do you fidget or squirm with your hands or feet when you have to sit for a long time?						
11.	How often do you leave your seat in meetings or other situations in which you are expected to remain seated?						
12.	How often do you feel tired or fidgety?						
13.	How often do you have difficulty unwinding and relaxing when you have time to yourself?						
14.	How often do you feel overly active and compelled to do things, like you were driven by a motor?						
15.	How often do you find yourself talking to much in social situations?						
16.	When you are in a conversation, how often do you finish the sentences of people you are talking to?						
17.	How often do you have difficulty waiting your turn in situations when turn talking is required?						
18.	How often do you interrupt others when they are busy?						
	PART B SCORE						
	TOTAL SCORE						

CHILD SELF REPORT SCALE: SYMPTOM CHECKLIST

Patients Name: ____ Date: _________________________

	Please answer all of the questions below, rating yourself in each of the criteria shown using the scale on the right side of the page. As you answer each question, circle the correct number that best describes how you have felt and conducted yourself over the past six months.	Never	Rarely	Sometimes	Often	Very Often	Score
1.	Inattention to detail: How often does your child make careless mistakes?						
2.	How often does your child struggle to sustain attention to work or play?						
3.	How often does your child not pay attention when spoken to?						
4.	How often is your child not able to follow or finish instructions?						
5.	How often is your child not able to finish work or tasks?						
6.	How often does your child exhibit poor organizational skills?						
7.	How often does your child avoid tasks requiring sustained attention?						
8.	How often does your child lose things?						
9.	How often is your child easily distracted?						
10.	How often is your child forgetful or “zoned out” in activities of daily living?						
	PART A SCORE						
11.	How often does your child fidget or squirm with his/her hands or feet when they have to sit for a long time?						
12.	How often does your child have trouble stay seated?						
13.	How often does your child display excessive and/or inappropriate physical activity such as running, climbing, jumping?						
14.	How often is your child inappropriately noisy while working or during leisure time?						
15.	How often does your child feel hype or revved up?						
16.	How often does your child talk excessively?						
17.	How often does your child impulsively answer before hearing the entire question?						
18.	How often does your child intrude or but in on conversations?						
19.	How often does your child have difficulty taking turns with others or awaiting his/her turn?						
20.	How often does your child interrupt or intrude on others activities?						
	PART B SCORE						
	TOTAL SCORE						

HEADACHE HISTORY

Name: ____ Date: ________________________________

It may seem strange to ask a person where their headache hurts, but the exact location in the head is important when it comes to helping us make an accurate diagnosis. Please read through the entire history, then answer each question to the best of your ability and as accurately as possible. If uncertain, leave blank.

1. Location

Indicate the area of your head where your headaches seem to be concentrated. Please check those that apply:

_____ A. Always on one side (R) _____ (L) _____

_____ B. Alternates

_____ C. Always on both sides

_____ D. Over eyes

_____ E. In eyes

_____ F. Under eyes

_____ G. Between eyes

_____ H. Behind eyes

_____ I. In temples

_____ J. In teeth

_____ K. Over cheeks

_____ L. In top of head

_____ M. In side of head

_____ N. In back of head

_____ O. In neck – back

_____ P. In ears

_____ Q. Other ____

2. How long have you had these headaches? ____

A. They have become:

_____ More Severe _____ Less Severe _____ Same Severity _____ More Frequent

_____ Less Frequent _____ Same Frequency

B. They occur:

_____ Daily _____ Weekly _____ Monthly

_____ Periodically (several headaches followed by periods of no headaches, only to recur several months later)

C. They begin:

_____ Slowly _____ Abruptly

D. They last:

_____ Seconds _____ Minutes _____ Hours _____ Days

3. Headaches occur most often: (Please check the appropriate blank

_____ Upon awakening in A.M. _____ Awakened in A.M. by headache _____ After getting up

_____ Late morning _____ Later in day _____ Late afternoon

_____ In evening _____ Awaken from sleep about 1-3 hours after going to bed

_____ In association with monthly cycle _____ Everyday for several days, then no headaches for a period of time

_____ Just before meals _____ 1-2 hours after meals

_____ Do you ever miss or skip meals and have headaches occur at time of normal meals

_____ Several hours after missing usual meal hour

_____ Other ____

4. Headache pain is best described as:

_____ Steady _____ Pulsating _____ Throbbing

_____Shooting (if so, write from where to where_ ____

_____ Other ____

5. Headaches are accompanied by: (please check Yes or No)

Yes No

___ ___ A. Blockage or obstruction to breathing through nose

___ ___ 1. If headache is on only one side, is nose obstruction on same side

___ ___ 2. Both sides

___ ___ B. Runny Nose

___ ___ 1. If headache on only one side, is runny nose on same side

___ ___ 2. Both sides

___ ___ C. Redness and watering of eyes

___ ___ 1. If headache is only on one side, are eye issues on same side

___ ___ 2. Both sides

___ ___ D. Changes in eyesight with headaches

___ ___ 1. Flashes of light

___ ___ 2. Decreased area of vision (tunnel vision)

___ ___ 3. Double vision

___ ___ E. Gastro-intestinal Symptoms

___ ___ 1. Nausea

___ ___ 2. Vomiting

___ ___ 3. Abdominal cramps

___ ___ 4. Diarrhea

6. List ALL medications you are now taking including non-prescription drugs (even birth control pills if taken)

____
____
____

7. Is there anything that you know that brings on a headache?

   ____
   ____
   ____

8. Is there anything that you know of that aggravates a headache?

   ____
   ____

9. Is there anything that makes your headache better?

   ____
   ____

10. Does reading or close work make headaches worse? ____
11. Does exertion make headaches worse? ____
12. Do you have any of the following diseases?

YES NO

___ ___ Arthritis

___ ___ Rheumatic disease

___ ___ High blood pressure (Hypertension)

___ ___ Diabetes

___ ___ Chronic kidney disease

___ ___ Ulcers of the stomach

___ ___ Asthma

___ ___ Hay fever

___ ___ Food allergies

___ ___ Chronic constipation

13. Please list all illnesses you have had for the past three years ____

____
____
____

14. Do you smoke? _______________ What _______________ How much ______________________
15. Do you use alcohol? ___________

    How much per day ____

16. Does headache ever occur within 30 minutes of alcohol use? ____________________________
17. Have you ever had a severe head injury"? ____

    When? ____

    What? ____

    How? ____

18. Have you ever had a severe neck injury? ____

    When? ____

    What? ____

    How (Auto accident, sports, fall, etc.) ____

19. Do you have:

YES NO

___ ___ Feelings of tenseness or anxiety with no real cause

___ ___ Financial problems

___ ___ Marital problems

___ ___ Problems with neighbors

___ ___ Problems with employer

___ ___ Problems with fellow employees

___ ___ Problems with children

___ ___ Problems with in-laws

___ ___ Other:

____

____

____

CHECKLIST OF CHANGES

Patients Name: ____ Date: _________________________

Please rate your symptom changes since your last session
Leave blank any symptoms which do not apply. Use the following letters:

"B" = Better "W" = Worse "NC" = No Change

	Impulsiveness		Pain awareness		Being "on time"
	Aggressiveness		Happiness		Forgetfulness
	Over Focus		Being organized		Feeling calm, relaxed
	Agitation		Aware of more dreams		Energy level
	Anxiety		Clear thinking		Fearfulness
	Anger		Reaction time		Difficulty staying asleep
	Obsession		Attention, concentration		Easier to wake up
	Compulsive behaviors		Having your act together		Frustration level
	Difficulty falling asleep		Reading		Feeling jumpy
	Nightmares		Fogginess		Can't slow down
	Body tension		Motivation		Negative thoughts
	Tics		Energy		Skin crawling sensations
	Headaches		Depression		Nausea
	Racing thoughts		Trouble staying asleep		Irritability
	Hyperactivity		Pain level		Confused thinking
	Excessive talking		Social interaction		Memory
	Headaches		Ability to complete tasks		Bed wetting

YES _____ NO _____ Have you had any changes in medications since last visit?

YES _____ NO _____ Have you had any changes in vitamins or herbs since last visit?

Please list any additional comments below and/or on the back of this page