The Balanced Brain
Neurofeedback Training Centers

Primary Concerns

- What is your major concern that led you to seek Neurofeedback training?

_____

_____

_____

- What other concerns do you have?

_____

_____

_____

- What are you hoping to accomplish with Neurofeedback training?

_____

_____

Prior evaluations and treatment

Please Indicate if you have attempted the following treatment:

☐ Psychiatrist
☐ Neurologist
☐ Cardiologist
☐ Alternative/Functional Medicine/Naturopathic (indicate type) _____
☐ Therapy (include type and duration) _____
☐ Other _____

- Are you currently in counseling or undergoing therapy of some type? _____

Please list any prior diagnoses and/or evaluations:

_____

_____

_____

Health and Medical History

- How is your overall health Excellent____Good_____Fair____Poor_____
- Current medical issues: _____

  _____
- Current supplements/vitamins/herbs:_____

  _____
- Name of Primary Care Physician: _____
- Other doctors/clinics seen currently: _____
- Allergies/drug intolerances (describe): _____
- Date of last physical exam: _____

Current medications you are taking (including cannabis products):

Medication *(dosage(s) and time(s) per day*	Reason Prescribed	Benefits	Side-effects/Problems

Have you ever had any:	Age(s)	Details
Migraines	_____	_____
Chronic pain	_____	_____
Frequent ear infections or colds	_____	_____
Serious illnesses	_____	_____
Major surgeries	_____	_____
Vision difficulties (not glasses)	_____	_____
Tinnitus (ringing in ears)	_____	_____
Speech or hearing disorders	_____	_____
Head Trauma/Concussion	_____	_____
Loss of Consciousness	_____	_____
Seizures	_____	_____
Texture Sensitivity	_____	_____
Noise Sensitivity	_____	_____

Nutrition History

- Would you consider your diet mostly healthy or unhealthy? _____
- Any food allergies/sensitivities? _____
- Are you currently on a special diet (i.e. vegan/vegetarian, low carb, gluten/casein free etc.) and what has been your experience?

  _____

  _____

  _____

  _____

- How many times a day do you eat? _____
- What is your typical eating schedule? _____

- Do you drink 6-8 glass of water per day? _____
- Caffeine consumption per day (i.e. coffee, soda, tea, chocolate): _____
- How many meals a week do you eat vegetables? _____
- Do you consider yourself over or underweight? _____

Exercise

- What exercise do you do and how often? _____

Sleep Behavior

- Any issues falling asleep? _____
- Any issues staying asleep (interrupted sleep)? _____
- Any issues waking up? _____
- On average, how many hours do you sleep per night? _____
- Any history of sleepwalking, recurrent dreams, sleep apnea, heavy snoring, or grinding your teeth? _____
  _____

Alcohol and non-prescriptive drugs

- How many alcoholic drinks do you consume on a weekly basis? _____
- Do you use any form of cannabis on a regular basis? If so, how often? _____
- Any use or history of use of other non-legal drugs (cocaine, LSD, Psilocybin, etc.) _____

  _____

Developmental and Social History

- Born where? _____ Raised where? _____
- Were you adopted? _____ If yes, at what age? _____
- Any delays in learning to crawl, walk or talk? _____
- Were you noticeably "hyperactive" as a child? _____
- Were you very anxious, fearful or shy as a child? _____

Adverse Childhood Events

While you were growing up, during your first 18 years of life

1. **Did a parent or other adult in the household often…**

   swear at, insult, or put you down?
   or
   act in a way that made you afraid that you would be physically hurt? If Yes enter 1 _____

2. **Did a parent or other adult in the household often…**

   push, grab, shove, slap or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured? If Yes enter 1 _____

3. **Did an adult or person at least 5 years older ever…**

   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try or actually have oral, anal or vaginal intercourse with you? If Yes enter 1 _____

4. **Did you often feel that…**

   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   If Yes enter 1 _____

5. **Did you feel often that**…

   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were to drunk or high to take care of you or take you to the doctor if you needed it?
   If Yes enter 1 _____

6. **Were your parents ever separated or divorced?** If Yes enter 1 _____

7. **Did your mother or stepmother…**

   Often pushed, grabbed, slapped or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   If Yes enter 1 _____

8. **Did you live with anyone who was a problem drinker or alcoholic, or used street drugs?**
   If Yes enter 1 _____

9. **Was a household member depressed or mentally ill or did a household member attempt suicide**?
   If Yes enter 1 _____

10. **Did a household member go to prison?** If Yes enter 1 _____

Total _____

Current Stresses

Are any of the following **current** source of stress?			How long has this been a problem?	How stressful? (1= Mild, 10= Very)
Concerns about a family member	Yes _____	No _____	_____	_____
Marital/relationship concerns	Yes _____	No _____	_____	_____
Adjusting to separation/divorce	Yes _____	No _____	_____	_____
Loss of friends/social isolation	Yes _____	No _____	_____	_____
School	Yes _____	No _____	_____	_____
Work	Yes _____	No _____	_____	_____
Health problems	Yes _____	No _____	_____	_____
Finances	Yes _____	No _____	_____	_____
Deaths or other losses	Yes _____	No _____	_____	_____

Other: _____

Details: _____

_____

_____

_____

Work History

- What do you do for a living? _____
- How is that affected by the presenting concern? _____
- Consider problems you have had in the past with work including either performance issues or work satisfaction. How much do you feel those problems were related to the current presenting concern?

  _____

  _____

- How good are you at getting things done? _____
- Do you work well independently? _____
- Do you use lists to organize and keep track of what needs doing? _____

School History

- Highest level of education _____ Last school attended _____
- Average grades received _____ Learning strengths _____
- Specific learning disabilities _____
- Any behavioral problems in school? _____
- What have teachers said about you? _____

Attention concerns

- What problems do you have with daydreaming, staying on-task or being disorganized? _____
  _____
- At what age was this first noticed at home? _____Did teachers ever report this as something they noticed too?
  _____
- What problems do you have with hyperactivity, stimulus seeking or feeling restless? _____
  _____
- At what age was this first noticed at home? _____ Did teachers ever report this as something they noticed too?
  _____
- What problems do you have with impulsivity, impatience or acting without thinking of consequences?
  _____
- At what age was this first noticed at home? _____ Did this ever lead to your being hurt or in danger? _____

  Explain _____

Oppositionality, anger and conduct concerns

- What problems do you have with being asked to do small tasks or requests? How much do you feel that any problems in this area come from not liking to be told to do things versus being distractible or disorganized?
  _____
  _____
  _____

- What problems do you have with irritability and anger? When angry, are you more likely to let the anger go quickly or hold onto resentment? _____
  _____

- When angry, does your temper frighten others? Do you ever become aggressive, violent or destructive?
  _____

- Have you ever had problems with the law? If so, have those problems continued into the present? Do you feel there is any connection between your presenting concern and problems with the law? _____
  _____
  _____
  _____

Depression

- What problems do you have with your feelings being too easily hurt or low self-esteem? _____
  _____

- What problems, if any, do you have with depression? _____
  _____

- If you are depressed, how much do you feel it may be directly a result of the major concern that you listed on the first page? _____
  _____

- Are you now thinking of hurting yourself? _____

Anxiety

- What problems do you have with anxiety? _____
  _____

- Are there situations or activities you avoid because of anxiety or fear of not doing well? _____
  _____

- In what ways do stress or anxiety cause you physical symptoms such as back or neck aches, headaches, intestinal problems or dizziness? How has that changed over time? _____
  _____
  _____

- Have you ever suffered a trauma such that you continue to show fear or avoidance when reminded of any of these events or being in similar situations? _____
  _____
  _____

- Do you have obsessive worries or compulsive behaviors? _____
  _____

- What problems do you have with tics? These are repetitive movements or noises such as eye blinking, facial twitching, or noises such as grunting, snorting, squeaking, or humming? _____
  _____

Alcohol and Drug Use

- Do you smoke cigarettes? Yes No If so, how much? _____

- How much coffee or other caffeinated beverages do you drink? What effect does caffeine have? _____
  _____

- Has anyone, including yourself, expressed concern about your alcohol use or have you ever sought help to control or stop drinking? Was this ever a problem when you were younger? _____
  _____
  _____
  _____

- If you use drugs, has anyone expressed concern about your use or have you ever sought help to control or stop using? Was this ever a problem when you were younger? _____
  _____

Other Concerns

- Do you have problems with social awareness such as not being aware of how another person might be feeling, recognizing unstated rules of what is "appropriate" or understanding body language or tone of expression?
  _____
  _____

- Do you have problems with the rules of conversation? Do you have problems knowing when the listener has lost interest? _____
  _____

- Do you often become so fascinated by one particular topic or interest such that it becomes all-consuming?
  _____

- Do you become upset by changes in routine or have problems shifting from one activity to another?
  _____