Restoration Counseling Service
Neurofeedback Assessment
_____

Name:
Date:
Age:
Sex:
Handedness (circle): left right both
Occupation:
Marital status (circle): single married divorced widowed

The following questions pertain to your entire health history. In other words, you should read the first question as, "Do you have difficulty falling asleep or *have you ever had difficulty falling asleep*?" If you answer yes to any of the questions in the section following, please offer a brief explanation as well. Include **when** (for example: currently, or 5 years ago) and well as **frequency** when appropriate (for example: headaches 2-3 times per week). The more your neurofeedback clinician can understand about you and your past, the more targeted the training can be. Your clinician will discuss this with you during your first session.

YOUR HEALTH STATUS

Sleep:

Do you often have difficulty falling asleep?

If so, how long does it typically take you?

Do you have restless/interrupted asleep?

Do you have difficulty waking?

Do you walk in your sleep or have night terrors?

Do you have dreams? Are they good dreams or bad ones?

Do you have any other sleep issues?

General:

Do you have any allergies?

Do you have asthma?

Do you suffer from frequent illness?

Do you suffer from fatigue? How often?

Do you have any skin problems?

Vision:

Do you have double vision?

Do you have blurred vision?

Do you have any blind spots?

Do you ever suffer from eye pain?

Do you have any visual sensitivity?

Hearing/smell:

Do you have any hearing loss?

Do you have ringing in your ears?

Do you have earaches?

Are you sensitive to smells?

Mouth/throat:
Do you grind your teeth?

Are you sensitive to tastes?

Heart/lungs:
Do you have any breathing problems?

Do you have any heart problems?

Do you have high blood pressure?

Stomach/digestion:
Do you have nausea or vomiting?

Do you have stomach pain?

Do you have intestinal pain?

Do you have frequent constipation?

Do you have irritable bowel syndrome?

Hormones:
Do you know when you are hungry or full?

Do you know when you are thirsty?

Do you crave sugar or avoid it?

Are you diabetic?

Are you overly sensitive to hot or cold?

Do you have a thyroid disorder?

Muscles:
Do you have frequent pain or stiffness?

Do you have a high pain tolerance?

Do you have frequent aching pain?

Do you have frequent nerve pain (burning or stabbing)?

Neurological:
Do you get headaches or migraines?

Do you ever faint or have seizures?

Do you have any speech problems?

Do you have any problems with balance?

Do you have any problems with coordination?

Are you accident prone?

Do you experience muscle twitching or vocal tics?

Attention/brain function:
What are your academic strengths?

What are your academic weaknesses?

Do you have a good sense of direction?

Do you struggle with concentration?

Do you have a good memory?

Do you become distract easily?

Are you impulsive (act without forethought)? This is different than being spontaneous.

Would you or others consider yourself hyperactive?

Pelvic region:
Do you ever lose control over your bladder or other functions?

(women only) Please describe any PMS symptoms?

(women only) Please describe any menopause symptoms?

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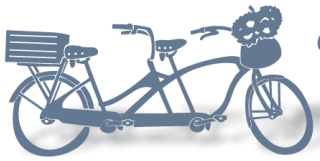

Restoration Counseling Service
Helping you to become all that you were created to be!

Habits:

Do you drink coffee?

Do you drink alcohol?

Do you smoke cigarettes?

Do you ever diet?

Do you use other drugs/medicines?

Do you regularly view pornography or have you in the past?

Behavior and Emotions:

Do you experience mood swings?

Are you frequently depressed?

Do you ever experience anxiety?

Do you have outbursts of anger or aggression?

Do you have panic (or anxiety) attacks?

Do you have any phobias/fears?

Do you have any obsessive-compulsive rituals?

Do you have any eating disorders?

Do you have any addictions?

PERSONAL HISTORY

Perinatal:

Did you suffer any prenatal stress or injury?

Are you aware of any prenatal drug exposure?

Did your mother experience a difficult labor when you were born?

Was the birth itself difficult?

Were you a premature or late birth?

Did you have any medical problems after birth?

Were you adopted? If so, at what age?

Growth and Development:

Were you colic at birth?

Did you have any sleeping problems?

Did you have any eating problems?

Do you recall any insecurities about your parents?

Were there any issues with your emotional development?

Were there any issues with your motor development?

Were there any issues with your language development?

Did you suffer chronic ear infections?

Did you have any allergies as a child?

Did you have asthma as a child?

Physical Traumas:
Did you ever suffer a head injury?

Did you ever suffer any accidents?

Did you ever suffer a high fever?

Did you ever suffer from a serious illness?

Did you ever suffer from a nervous system infection? (meningitis, etc.)

Did you ever suffer from a drug overdose?

Did you ever suffer from poisoning?

Were you ever unable to breath?

Have you ever had a stroke?

Psychological Traumas and Stresses:
Did you suffer an abuse or neglect as a child?

Was there any significant family stress?

Have you had any significant school or job stress?

Has there been a death in the family that was extremely difficult for you?

Have you ever had any substantial illnesses?

TREATMENT HISTORY

Medications:

Please list any medications you take currently or in the past, what they were taken for, and the approximate dates.

Medical Treatment:

Please list any medical treatments you have received, what condition the treatments were for, and the approximate dates.

Psychological Therapy:

Please list any psychological therapy you have received, why you were seeking it, and the approximate dates.

Other Therapy:

FAMILY HISTORY

Keeping in mind all of the things just discussed about your history, please note any medical or psychological family history in the space provided.