Therapeutic Options
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Neurofeedback Assessment Interview

Name of Client: ________________________________
Date of Birth: ________________________________
Today's Date: ________________________________
Right or Left Handed ____________________________
Name of Person Completing Form: _______________________________

Directions: If you are completing this form for someone else the substitute "you" or "your" with information about the client. Please answer each question as completely as possible. Use the back of the page if necessary. Thank you.

1. How is your general health?

2. Do you have any problems with your respiratory system, any trouble breathing, asthma, environmental allergies, sinus infections?

3. Do you have any problems with your cardiac system, any heart related difficulties, high blood pressure, family history of heart problems?

4. What if any, medications are you now taking, (including over the counter, supplements and vitamins)

5. What are you taking these for and what is your response to each of them, do you experience any side effects?

6. What medications, over the counter drugs, vitamins or supplements have you taken in the past, for what and what was your response, did you have any side effects?

7. Why did you discontinue the use of these?

8. Do you have any difficulty with your skin? Any dry patches, eczema, psoriasis, rashes? Are there times when stress or emotional issues contribute to these problems?

9. Do you have any vision problems?

10. Do you have any hearing difficulties, ringing in ears, history of multiple ear infections, vertigo, misunderstanding what has been said?

11. Do you have any digestive difficulties? Do you have any problems with nausea or vomiting, upset stomach, constipation or diarrhea, acid reflux or frequent heart burn?

12. Do you have any difficulties with allergies, or sensitivity to anything, foods, food additives, medications?

13. Do you have any problems with your endocrine system?

14. Any thyroid problems or family history?

15. Any diabetes or family history?

16. Do you have any difficulties with your periods, any PMS?

17. Any difficulties with menopause?

18. Have you ever had surgery, any anesthesia?

19. Have you ever had any accidents, or been to the emergency room?

20. Have you ever received treatment under emergency circumstances that did not involve an accident?

21. Have you ever had any kind of head injury? Any falls, accidents or other incidents involving your head?

22. Do you have any chronic problems?

23. Do you have any problems with pain?

24. Do you have fatigue that is not related to daily activities?

25. Do you have any problems with your musculoskeletal system? Any difficulties with your bones or muscles, any twitches or tics?

26. Do you experience any tremors or spasticity?

27. What is your response, if any, to the following:

    a) Caffeine?

    b) Alcohol?

    c) Sugar?

28. Any other experiences with other substances?

29. Are you sensitive in general to medications? Do you usually take a smaller than average dose?

30. Do you ever get headaches?

   a) If so, what can you take or do to get rid of them?

   b) Are they related to any foods or other activities?

   c) Are they related at all to the menstrual cycle?

   d) Are they tension headaches?

   e) Are they migraine headaches?

31. Have you ever fainted, or lost consciousness?

32. Have you ever had a seizure, any family history of seizures?

33. Have you ever had a high fever? (over 103 for adults, over 106 for small children)

34. How would you rate your physical activity level, now and in the past? Do you fidget or feel a need to move? Is this constant or just under certain circumstances? (overactive, underactive?)

35. How would you rate your coordination? During daily activities, during sports? Are you considered accident prone?

36. How is your ability to balance? Can you usually catch a ball that is thrown to you? Can you ride a bike?

37. How is your awareness of your physical body space? Do you know when people are standing too close? Do you know when you are standing too close to others?

38. Are you a picky eater? Are you uncomfortable with mixed foods? (things that contain more than one kind of ingredient)

39. Do any particular smells bother you enough to need to avoid them?

40. Do you complain about being either hot or cold when no one else is?

41. Do you often misunderstand what is said if you are not close to the speaker? Do you have difficulty understanding if there are other noises going on?

42. Any difficulty with voice volume modulation?

43. How are your spatial skills? Are you able to do things like puzzles or manipulate small pieces easily?

44. Are you sensitive to any kind of lighting?

45. Do you respond in the expected fashion to being touched?

46. Are light touches uncomfortable?

47. Are you bothered by tags inside clothing or seams in clothes or socks?

48. Are there textures that you do not like to tolerate?

49. Do you have any difficulty with sleep?

50. Any difficulty falling asleep?

51. If yes, please describe your experience. Are you likely to have lots of thoughts or more likely just blank mind?

52. Do you sleep through the night? If not how often do you wake, is your mind busy and how difficult is it to go back to sleep?

53. Are you a restless sleeper with lots of movements or mostly still?

54. Are you mostly a sound sleeper or a light sleeper?

55. Do you now sleep walk or talk, any history of these?

56. Any problems with bruxism (teeth grinding)?

57. Do you wake with any jaw pain?

58. Do you have nightmares or night terrors, any history of?

59. Are there any problems with bed wetting?

60. What is it like for you to wake up in the morning, do you feel rested?

61. How long does it take you to feel “awake” and ready to proceed with your day?

62. Please describe your morning routine. (Do these activities seem to invite or discourage stimulation?) Do you want a quiet undisturbed beginning to your day or is it better for you to have some noise (TV, radio) or other activity going on?

63. For children: What kinds of activities are soothing? (Likes being more active, being held while walking or bouncing or more likely to be soothed by soft quiet kinds of activities)

64. Adults: If you have had a really terrible day, what kinds of activities would you chose to make yourself feel better? (Look for activities that show withdrawal or avoiding any stimulation vs. activities that are more physical like walking or bike riding, activities that invite stimulation)

65. Under what circumstances are you most likely to get work done? Do you function better in a quiet, familiar place with few distractions or are you more likely to work best under pressure or at the last minute (procrastination) and can do this with other things going on in the background.

66. Are your moods fairly stable and predictable (do you have a reason for and understand why you are in the mood you are in?) Do you have times when your mood does not match with what you are going through?

67. Do you experience depression?

68. Do you experience anxiety?

69. Have you ever had a panic attack? Under what kind of circumstances?

70. Do you have any phobias?

71. What is anger like for you? Do you tend to keep it bottled up, are you more likely to express it, and if you express it what is that like?

72. Are you able to control your anger? If the reason for the anger ends, does your anger also end or is it difficult to stop being angry?

73. Do you have angry outbursts, tantrums or any violent behaviors?

74. Are you irritable often?

75. Do you have any difficulty with obsessive thoughts or compulsive behaviors? If so, what are they? When are you most likely to experience these?

76. Does your mind race with thoughts? If so when is it most likely to happen?

77. Do you have any difficulty with eating disorders?

78. Do you have or is there a family history of addictions?

79. How do you respond to risk taking kinds of behavior? Are you comfortable with these or do you avoid these?

80. Do you have any oppositional behaviors or do others consider you oppositional, when is this most likely to happen?

81. How do you manage transitions? At home? At work? Social settings?

82. How would you describe your frustration tolerance levels?

83. Do you worry? If so are you more likely to worry to yourself and not let others know much about your worries or are you more comfortable if you let others know and then they participate in the worry?

84. Do you consider yourself to be flexible in your behaviors? Please describe some situations where you feel you have been flexible.

85. Are you ever aggressive? When is this most likely?

86. Is it easy for you to be aware of others feelings and interpret this correctly?

87. Are any of your behaviors considered manipulative?

88. What is your most common responded to stress? How do others see you when you are stressed?

89. How are your organizational abilities?

90. Do you have any difficulty with attention span?

91. Do you have trouble getting back on task if you have been distracted? Does it take a long time to get back on task, what helps you get back on task?

92. Are you impulsive?

93. Does daydreaming interfere with being able to pay attention?

94. Are there subjects that you are especially good in?

95. Are there subjects that you have difficulty with?

96. Are any teachers expressing concerns?

97. Are there any problems with homework?

98. Do you like to read? What are you most likely to read? Books, newspapers, magazines?

99. How is your memory? What kinds of things cause difficulty with memory?

100. If you have trouble, what do you have trouble remembering?

101. How is your ability to interact with others? Your peers? Adults? (if children)

102. Is there any information about early development stages?

103. Any pertinent information about the birth or birth events?

104. What other medications therapies or interventions have you tried? Please comment on the effects of each.

105. Any important family history regarding your complaints?

106. What are the greatest concerns and areas most in need of change?