Date of Assessment:

____/____/____ (Office Use)

New Jersey Institute for Neurofeedback and Neurotherapy

317 Cleveland Ave. Highland Park, New Jersey. 09804

Neurofeedback Assessment Questionnaire

ADULT

Name: _____ **Birth Date:** ____/____/____

Address: _____ **Age:**_____

City: _____ _____ **State:** _____ **ZIP**_____

Email:_____ **Do you check it regularly? YES NO (circle one)**

Marital Status: Single Married Divorced

Phone: H: _____-_____-_____ **W:** _____-_____-_____ **C:** _____-_____-_____

Can we leave messages on these numbers Yes No

Emergency Contact: Name _____**Relationship:**_____

Emergency Contact Phone#: (_____) _____

Gender: Gender (circle one): Male Female Intersex Transgender (M to F) Transgender (F to M)

Occupation:_____

Main Goals: Let us know the major things you would like to accomplish; what are your major concerns? (Please be as specific as possible)

1)_____

2)_____

3)_____

4)_____

5)_____

Do you have a history of epilepsy or seizures? Yes No

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Do you have a history of migraines? Yes No …sensitivity to light? Yes No

Any Children? Please List Names, Genders, and Ages:

Name: M F Age Name: M F Age Name: M F Age

Name: M F Age Name: M F Age Name: M F Age

Any Siblings? Please List Names, Genders, and Ages:

Name: M F Age Name: M F Age Name: M F Age

Name: M F Age Name: M F Age Name: M F Age

Have you ever been given a <u>medical</u> diagnosis? Yes No

Diagnosis _____ Date Diagnosed _____ Who diagnosed you? _____

Diagnosis _____ Date Diagnosed _____ Who diagnosed you? _____

Diagnosis _____ Date Diagnosed _____Who diagnosed you? _____

Have you ever been given a <u>psychological/psychiatric diagnosis</u>? Yes No

Diagnosis _____ Date Diagnosed _____ Who diagnosed you? _____

Diagnosis _____ Date Diagnosed _____ Who diagnosed you? _____

Are you currently under treatment or the supervision of a health care provider? Yes No

For what condition(s)?_____

Who is your primary health care provider?

_____

Have you participated in any psychological therapies (with a psychologist, social worker, counselor, family therapist)? Yes No

Are you currently in psychotherapy? Yes No

If so with whom?_____

Name:_____ **Date of Assessment:** ____/____/____ (Office Use)

Dates in psychotherapy? Beginning: _____/_____/_____ End:_____/_____/_____

Have you been seen by a psychiatrist? Yes No

Name of psychiatrist: _____ Dates seen:_____

Name and specialty of your medical doctor:_____ Dates seen:_____

Have you had blood work done in the last 6 months? Yes No If so, from which lab?_____

Do we have permission to contact any of the above providers/and or labs? Yes No

MEDICATION HISTORY

Are you currently or recently on any medications, drugs, hormone replacement, allergy or asthma treatments, alternative therapies, nasal sprays, or any regular use of OTC medications? Please list name, dosage, and indication for use:

Name:	Start Date	Dosage	What are you taking it for?

DO YOU TAKE SUPPLEMENTS?

Please List:

Name:	Start Date	What Are You Taking it For?

Name:_____ **Date of Assessment:**
____/____/____ (Office Use)

Assessment Notes (For Clinician):_____

Name:_____ **Date of Assessment:**
____/____/____ (Office Use)

_____

_____

_____

On a scale of 1 to 10 (with 10 being the best) how would you rate your overall health?

1 2 3 4 5 6 7 8 9 10

(Poor) (Fair) (Good) (Excellent)

For the following lists please put a ✔ next to any symptoms that you are CURRENTLY experiencing.

Please put an X next to any symptoms that you have had in the PAST but do not have now.

ATTENTION SYMPTOMS

▪ ___ADD (Attention Deficit Disorder) ▪ ___Inattention (Internal) (Difficulty paying attention) ▪ ___Poor concentration ▪ ___Lack of motivation ▪ ___Day Dreaming	▪ ___ADHD (Attention Deficit Hyperactivity Disorder) ▪ ___Hyperactivity after sugar or other foods ▪ ___Hyperactivity after taking sedatives ▪ ___Overwhelmed by stimuli ▪ ___Difficulty making decisions ▪ ___Disorganized	▪ ___Impulsivity ▪ ___Distractibility (external) ▪ ___Stimulus seeking ▪ ___Thrill seeking ▪ ___Competing thoughts (too many thoughts)

Assessment notes: (For Clinician)

_____

_____

Name:_____ **Date of Assessment:**
____/____/____ (Office Use)

_____

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_____

SLEEP SYMPTOMS

(Put a ✔ next to Current symptoms, put a X next to any symptom/feeling you've had in the Past, but are not experiencing now)

▪ ___Night Sweats ▪ ___Frequent waking during the night (without agitation) ▪ ___Sleeping lightly ▪ ___Sleeping too much ▪ ___Not feeling rested after sleep ▪ ___Waking early ▪ ___Difficulty falling asleep (mind is quiet) ▪ ___Sleep Apnea (non-obstructive) ▪ ___Snoring	▪ ___Night Terrors ▪ ___Nocturnal myoclonus (jerking or moving while sleeping) ▪ ___Sleepwalking ▪ ___Sleep talking ▪ ___Narcolepsy (falling asleep frequently or suddenly during the day) ▪ ___Too busy to sleep (manic quality) ▪ ___Sleep paralysis when awakening (still dreaming when awake) ▪ ___Bed wetting (Enuresis)	▪ ___Difficulty falling asleep (busy mind) ▪ ___Hot flashes during sleep ▪ ___Physically restless sleep ▪ ___Nightmares ▪ ___Bruxism (grinding teeth) ▪ ___Restless Leg Syndrome ▪ ___Clenching jaw ▪ ___Waking up with agitation ▪ ___Startle easily from sleep (vigilant sleeper) ▪ ___Vivid dreams

Do you nap? YES NO SOMETIMES

What time do you usually go to bed? _____

What time do you get up? _____

How long does it take for you to fall asleep? _____

Name:_____ **Date of Assessment:** ____/____/____ (Office Use)

How many hours of sleep do you get a night? _____

Are you able to sleep through the night? Yes No

How often do you wake up at night?_____

If you wake up during the night is it because you need to use the bathroom? Yes No

Are you able to fall back asleep easily? Yes No

Do you share your bed with someone? Yes No

In your bedroom, when falling asleep, is there a screen on (TV, computer, tablet, iPhone)? Yes No

Where is your cellphone when you sleep (switched on, at bedside, in another room)? _____

How long before going to sleep do you usually stop watching TV or use a computer, iPad, iPhone?_____

In bed, what do you usually do before sleep (texting, reading, chatting, watching videos)?_____

Do you operate a home WiFi (wireless network) where is it located_____and what do you do with it?_____

Do you dream in color? YES NO SOMETIMES

Rate the quality of sleep that you've gotten in the last month?

1 2 3 4 5 6 7 8 9 10

(Poor) (Fair) (Good) (Excellent)

Sleep Symptoms Assessment Notes: (for Clinician)

_____

_____

_____

_____

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_____

_____

_____

Name:_____ **Date of Assessment:**

____/____/____ (Office Use)

EMOTIONAL AND BEHAVIORAL SYMPTOMS

(Put a ✔ next to Current symptoms, put a X next to any symptom/feeling you've had in the Past, but are not experiencing now)

▪ ___Anxiety (worry) ▪ ___Depression (blue, low) ▪ ___Helpless and hopeless ▪ ___Irritability ▪ ___Passivity ▪ ___Feelings easily hurt ▪ ___Perfectionist ▪ ___Remorseful after tantrums ▪ ___Cry easily (feelings hurt) ▪ ____Frequent crying ▪ ___Rumination (revisiting things over and over) ▪ ___Guilt ▪ ___Withdrawal when stressed ▪ ___Passive ▪ ___"I wish I was dead" ▪ ___Grumpy ▪ ___Think little of yourself	▪ ___Binge eating ▪ ___Anorexia ▪ ___Bulimia ▪ ___Panic attacks ▪ ___Encopresis (soiling) ▪ ___Irritable Bowel Syndrome (IBS) ▪ ___Bipolar Disorder ▪ ___Dissociative Identity Disorder (DID) ▪ ___Borderline Personality Disorder (BPD) ▪ ___Posttraumatic Stress Disorder (PTSD) ▪ ___Developmental Trauma ▪ ___Rages ▪ ___Antisocial Personality Disorder (APD)	▪ ___Shame ▪ ___Compulsive behavior ▪ ___Involuntary movements or tics ▪ ___Impatient ▪ ___Aggressive; initiates conflict ▪ ___Jealous/envious ▪ ___Angry ▪ ___Lack remorse ▪ ___Hate self ▪ ___Dissociative ▪ ___Exhausted ▪ ___Lack empathy ▪ ___Lack cause and effect thinking ▪ ___Hold grudges ▪ ___Manipulative, controlling ▪ ___Poor comprehension and expression of emotions ▪ ___Lack body awareness (pain, discomfort, appetite) ▪ ___Poor eye contact ▪ ___Poor social awareness ▪ ___Attachment disorder (history)

Name:_____ **Date of Assessment:** ____/____/____ (Office Use)

▪ **___Performance anxiety** ▪ **___Fear of criticism** ▪ **___Shy** ▪ **___Overly sensitive** ▪ **___Seasonal Affective Disorder (SAD)** ▪ **___Fidget** ▪ **___Whine** ▪ **___Obsessive thoughts** ▪ **___Jealous/envious**		▪ **___Developmental trauma Anxiety (fear)** ▪ **___High pain threshold** ▪ **___Loud unmodulated voice (tone does not vary)** ▪ **___Depression (irritable)** ▪ **___Agitation** ▪ **___Mania** ▪ **___Paranoia** ▪ **___Suicidal thoughts or actions** ▪ **___Autistic symptoms** ▪ **___Humorless** ▪ **___Road Rage** ▪ **___Hair pulling or twirling** ▪ **___Nail biting (nervous habits)** ▪ **___Attachment Disorder (history)** ▪ **___Developmental Trauma**

Do you consider yourself a defensive or offensive driver? _____

Assessment notes: (For Clinician)

_____

_____

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_____

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_____

Name:_____ **Date of Assessment:**
____/____/____ (Office Use)

COGNITIVE SYMPTOMS

(Put a ✔ next to Current symptoms, put a X next to any symptom/feeling you've had in the Past, but are not experiencing now)

▪ ___Dyslexia ▪ ___Indecisiveness ▪ ___Inability to plan and follow through ▪ ___Poor reading comprehension ▪ ___Difficulty reading aloud ▪ ___Poor arithmetic calculation		▪ ___Poor spelling ▪ ___Frequently bump into things ▪ ___Difficulty reading ▪ ___Speak in monotone ▪ ___Poor drawing ▪ ___Loud voice ▪ ___Inability to write neatly ▪ ___Poor fine motor skills ▪ ___Poor sense of direction ▪ ___Poor math concepts ▪ ___Confuse Left and right

Assessment notes: (For Clinician) _____

Name:_____ **Date of Assessment:**
____/____/____ (Office Use)

PAIN SYMPTOMS

(Put a ✔ next to Current symptoms, put a X next to any symptom/feeling you've had in the Past, but are not experiencing now)

▪ ___Chronic pain with depression ▪ ___Chronic aching pain ▪ ___Tension headache ▪ ___Feel pain easily	▪ ___Fibromyalgia ▪ ___Reflex Sympathetic Dystrophy (RSD) ▪ ___Trigeminal Neuralgia ▪ ___Migraine ▪ ___Headaches ▪ ___Jaw tension ▪ ___Motion sickness	▪ ___Chronic burning pain ▪ ___Chronic throbbing pain ▪ ___Chronic stabbing pain ▪ ___Chronic shooting pain ▪ ___Sciatic pain ▪ ___Can tolerate pain easily ▪ ___Peripheral neuropathy (Pain in extremities {arms/legs}) ▪ ___Emotional reactivity to pain ▪ ___Acid Reflux

Do you prefer to write in cursive or in print? _____

Are you left handed or right handed? Please Circle

Name:_____ **Date of Assessment:**
____/____/____ (Office Use)

Assessment notes: (For Clinician)

_____

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_____

NEUROLOGICAL AND MOTOR SYMPTOMS

(Put a ✔ next to Current symptoms, put a X next to any symptom/feeling you've had in the Past, but are not experiencing now)

▪ ___Left-brain seizures ▪ ___Left-brain stroke ▪ ___Left-brain TBI (Traumatic Brain Injury) ▪ ___Right body paralysis or muscle weakness ▪ ___Enuresis (urinary incontinence)	▪ ___Generalized seizures ▪ ___Absence (petit mal) seizures ▪ ___Tonic-clonic (grand mal) seizures ▪ ___Temporal lobe epilepsy ▪ ___TBI with brainstem injury ▪ ___Vertigo ▪ ___Tinnitus ▪ ___Motion sickness ▪ ___Tics	▪ ___Right-brain partial seizures ▪ ___Right-brain strokes ▪ ___Right-brain TBI (Traumatic Brain Injury) ▪ ___Left body paralysis or muscle weakness ▪ ___Spasticity ▪ ___Tremor ▪ ___Poor balance ▪ ___Poor coordination ▪ ___Involuntary regurgitation ▪ ___Nervous habits/laugh ▪ ___Reflux ▪ ___Hiccups

Name:_____ **Date of Assessment:** ____/____/____ (Office Use)

Assessment notes:

_____

_____

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IMMUNE, ENDOCRINE, AND AUTONOMIC NERVOUS SYSTEM SYMPTOMS

(Put a ✔ next to Current symptoms, put a X next to any symptom/feeling you've had in the past, but are not experiencing now)

▪ ___Sugar craving ▪ ___Immune deficiency ▪ ___Low Thyroid Function ▪ ___PMS Depressive Symptoms: -Irritability -Insomnia -Sugar craving -Cramps -Pain ▪ ___Postpartum depression ▪ ___Insomnia ▪ ___Intolerant of alcohol or other sedative drugs	▪ ___Hypertension ▪ ___Hypotension ▪ ___Incontinence ▪ ___Severe PMS (migraine with mood swings) ▪ ___Chronic Fatigue Syndrome (CFS) ▪ ___Irritable Bowel Syndrome (IBS) ▪ Asthma ▪ ___Autoimmune disorders: ○ Type I diabetes ○ Lupus ○ Crohn's Disease ○ Rheumatoid Arthritis ○ Multiple Sclerosis ○ Hashimotos Disease	▪ ___Irregular menstrual periods ▪ ___Racing thoughts ▪ ___Menopausal hot flashes ▪ ___Mania ▪ ___Rage ▪ ___PMS—High Arousal: ○ Agitation ○ Mania ○ Rages ○ Racing thoughts ▪ ___Menopausal hot flashes ▪ ___Itching/rash ▪ ___Skin allergies ▪ ___Other Allergies ▪ ___Heart palpitations

Name:_____ **Date of Assessment:** ____/____/____ (Office Use)

	○ **Graves Disease** ○ **Sjogren's Syndrome** ▪ **___Intolerant of coffee, alcohol, and many medications** ▪ **___Multiple chemical sensitivities**	▪ **___Pounding, racing heart** ▪ **___Constipation** ▪ **___Intolerant of coffee and other stimulant** ▪ **___Eczema**

Assessment notes: (For Clinician)

_____

_____

PERSONAL HISTORY

Prenatal History_____

Birth Events (i.e. maternal stress, accident, drug exposure, difficult labor, forceps delivery, breech birth, induced labor, Pitocin, anesthesia, anoxia, premature/late delivery?)_____

_____

Post Birth Problems? _____

Other? Please describe:_____

Problems with growth and development during childhood (please explain):

Severe Recurrent Illnesses or Infections-_____

Allergies-_____

Emotional Difficulties-_____

Behavioral Problems-_____

Name:_____ **Date of Assessment:** ____/____/____ (Office Use)

Appetite/ Digestion Issues-_____

Language/Speech Issues-_____

Coordination Issues-_____

Walking (before 15 months) or talking early (full sentences before 3 years)-_____

Walking (after 15 months) or talking late (no full sentences after 3 years)-_____

History of ear infections-_____

List all childhood medications (even over-the-counter)/ reasoning for taking:

Name:_____ **Reason for taking:** _____

_____ _____

_____ _____

Assessment Notes: (For Clinician)-_____

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Name:_____ **Date of Assessment:**
____/____/____ (Office Use)

Physical Trauma

Head Injury/ Traumatic Brain Injury/Coma:

Injury (broken bones/sprains/strains/dislocations)-_____

Have you ever injured your head or neck?	**Yes**	**No**
Did you ever hit your head VERY hard or had a concussion?	**Yes**	**No**
If yes, have you suffered more than one concussion?	**Yes**	**No**
Did you, or do you currently play contact sports?	**Yes**	**No**
Have you ever been in an auto, motorcycle, or bicycle accident?	**Yes**	**No**
Have you ever had a traumatic brain injury?	**Yes**	**No**
If yes, are you currently receiving care for this/these injuries?	**Yes**	**No**

Date of Accident/Event/ Head Injury/ Traumatic Brain Injury/Coma:	**What Happened?**

Name:_____ **Date of Assessment:** ____/____/____ (Office Use)

Any surgeries, hospitalizations, anesthesia or medical treatments? Please describe.

_____

_____

High Fever-_____

Serious Illness-_____

CNS infection-_____

Poisoning-_____

Anoxia-_____

Stroke-_____

Heart attack-_____

Ever Broken your Nose? _____

Have you ever been to the emergency room? Please describe._____

Assessment Notes: (For Clinican):_____

Name:_____ **Date of Assessment:** ____/____/____ (Office Use)

LIFESTYLE INVENTORY

Do you drink alcohol? Yes No

If so, how often per week?_____

How many drinks each time you drink?_____

How old were you when you began drinking?_____

How does drinking affect you?_____

Do you drink caffeine (soda, tea, coffee, energy drinks)? Yes No

How many drinks per day?_____

What time during the day? _____

How does it affect you?_____

Do you smoke? Yes No

If so, how many cigarettes a day? _____

How long have you smoked?_____

Do you use/have you used any other recreational drugs? i.e.:

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Marijuana? **Yes** **No** **How often?**_____

Cocaine? **Yes** **No** **How often?**_____

Ecstacy/MDMA/Molly? **Yes** **No** **How often?**_____

LSD/Magic Mushrooms/PCP? **Yes** **No** **How often?**_____

Benzoes? **Yes** **No** **How often?**_____

Blues? **Yes** **No** **How often?**_____

Heroin? **Yes** **No** **How often?**_____

Oxycontin? **Yes** **No** **How often?**_____

Xanibars? **Yes** **No** **How often?**_____

Methanphetamine? **Yes** **No** **How often?**_____

Cold Medicine/Sizzurp? **Yes** **No** **How often?**_____

K2/Spice? **Yes** **No** **How often?**_____

Inhalants? **Yes** **No** **How often?**_____

Bath Salts? **Yes** **No** **How often?**_____

Prescription Drug Abuse? (Adderall, Cough Syrup, Sleep Aides, Vicoden, etc…)

Yes **No** **How often?**_____

Have you ever had a drug overdose? If so, when?_____

Self-Injury

Have you ever self-injured? **Yes** **No**

How? (Please circle all that apply):

Scratching or pinching **Punching or hitting objects** **Cutting**

Punching or hitting oneself **Ripping skin** **Carving**

Name:_____ **Date of Assessment:** ____/____/____ (Office Use)

Interfering with healing **Burning** **Rubbing sharp objects into the skin** **Hair pulling**

Diet Information

Do you like sugar/sweets? _____

Candy? **Cake?** **Ice Cream?** **Cookies?** **Fruit?** **Other?**

How does it affect you?

_____

Do you eat chocolate? **Yes** **No**

How much?_____

How often? _____

Do you crave salt? **Yes** **No**

What are your three favorite foods?

_____

_____

_____

How many hours a day do you watch TV on weekdays?_____

On weekends?_____

Do you play computer games? **Yes** **No**

How many hours a day?_____

Do you read for pleasure? **Yes** **No**

What do you do to relax?

_____

_____

Do you exercise? **Yes** **No**

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What types of exercise? _____

_____

How many times per week?_____

Do you have sensitivity to light such as discomfort with fluorescent lights, glare, or computer screens?

Yes No

Do things seem too loud? Yes No

Are you bothered by tags or seams on clothing? Yes No

Any sensory or auditory processing problems? Please describe.

_____

_____

<u>Psychological stresses or life changes during childhood</u>:

Death of a loved one?_____

Parent's divorce?_____

Losses?_____

Moves?_____

School Changes?_____

Or in adulthood?

Work stress?_____

Job change or loss?_____

Family Stress?_____

Loss of loved one?_____

Illness?_____

Financial Stress?_____

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Family Stressors?_____

Did you/do you experience emotional or physical abuse or neglect? Did you witness acts of violence?

Please describe.

_____

_____

Assessment Notes: (For Clinician)-_____

_____

_____

SEXUAL HISTORY

History of sexual abuse?

_____

_____

_____

_____

History of sexual dysfunction? **Yes** **No**_____

Erectile Dysfunction ? **Yes** **No**_____

Difficulty getting aroused or staying aroused? **Yes** **No**_____

Difficulty achieving orgasm? **Yes** **No**_____

Painful intercourse? **Yes** **No**_____

Do you have concerns about your libido?_____

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Assessment Notes (For Clinician)-_____

FAMILY HISTORY

Do you have any close relatives who experienced problems such as:
(Mother/Father/Paternal or Maternal Grandparents/Siblings/Aunts/Uncles)

Epilepsy_____

Autism_____

ADHD_____

Asperger's_____

Alcoholism_____

Drug Addiction_____

Depression_____

Anxiety_____

Mental Illness_____ **(What Diagnosis)**_____

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Suicide_____

Incarceration_____

Auto Immune Disease_____

Assessment Notes: (For Clinician)-_____

_____

_____

_____

_____

_____

_____

Have you had any educational therapies? **Yes** **No**

Tutors? **Yes** **No**

Special Schools? **Yes** **No**

Resource Teachers? **Yes** **No**

Vision or Speech Therapy? **Yes** **No**

Occupational Therapy? **Yes** **No**

Other? **Yes** **No**

Please describe.

_____

_____

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____/____/____ (Office Use)

Have you ever had neurological or educational testing?

_____

_____

Do you have copies of these test results? Y or N

May we obtain a copy? Y or N

Signature:_____**Date:**_____

Signature of Guardian:_____**Date:**_____

Thank you for taking the time to fill out this form.

This information will help us to provide you with the best possible care.

*On the following page please draw a picture of your family

Name:_____ **Date of Assessment:**
____/____/____ (Office Use)