Release Neurotherapy

CLIENT INFORMATION FORM

Name: _____ Date of Birth: ___/___/____

(Including middle names) Age:

Assessment Date: ___/___/____

Handedness: L R Mixed

Address: _____

City/PostCode: _____

Home Phone:_____Mobile_____

Email:_____

Emergency contact: _____Phone_____

Child Intake Information

Mother's Name: _____

Father's Name: _____

Names and ages of siblings: _____

_____

School year: _____

Reasons for doing Neurofeedback. What are the primary issues you would like to address?

_____

_____

_____

Sleep

How would you rate your sleep in the past month on a scale of 1 to 10, 1 being very poor, 10 being excellent: ____

How many hours sleep do you have per night on average? ____

Difficulty falling asleep? Yes No

Difficulty waking? Yes No

Do you wake during the night? Yes No

Do you feel fatigue or tiredness during the day? Yes No

Other sleep problems? Please describe:

_____

_____

_____

Emotion and Behaviour

Please tick any of the following emotions or behaviours that are prevalent in your daily life:

__ Anger/irritability/aggression
__ Anxiety/panic attacks
__ Depression
__ Obsessive worry
__ Fear
__ Schizophrenia
__ PTSD
__ Poor social awareness
__ Phobias
__ Mood swings
__ Obsessive-compulsive behaviours
__ Eating disorders
__ Addictions
__ Inflexible/Oppositional
__ Passive/Shy
__ Poor Diet

Any other emotional concerns? Please describe

_____

_____

_____

Cognition and Attention

Please tick any of the issues below that you experience in daily life:

__ Attention/focus problems
__ Brain fog/fuzzy thinking
__ Memory problems
__ Learning Difficulties
__ Procrastination
__ Maths problems
__ Difficulty making decisions
__ Distractibility/Impulsivity/Hyperactivity
__ Reading/Spelling problems
__ Overwhelmed by stimuli

Other:

_____

_____

Physical Health/Pain/Motor Issues

Please tick any of the issues below that you experience in daily life:

__ Headaches/Migraines
__ Pain
__ Hearing problems/Tinnitus
__ Vision problems
__ Allergies
__ Asthma
__ Diabetes
__ Body warm or cold
__ Skin problems
__ Poor Balance
__ Poor coordination
__ Sensory processing issues
__ Finger or foot tapping/Motor tics
__ Vocal tics
__ Poor fine motor or writing skills
__ Digestion Problems/IBS
__ Hypertension
__ Other

Use of Caffeine (coffee, tea, fizzy drinks) Yes No Details: _____

Use of tobacco Yes No Details: _____

Use of Alcohol or drugs Yes No Details: _____

Screen time per day (hrs) _____

Do you consider your use of any of these substances, or screen time, to be a problem? Yes No

Family History

Have any of your immediate family (mother, father, grandparents, siblings) suffered from any of the issues listed below? Please tick any relevant issues and state which family member.

_____ Allergies	_____ Migraine/Headaches
_____ Motor or Vocal Tics	_____ Asthma
_____ Schizophrenia	_____ Autism Spectrum
_____ Arthritis	_____ Manic/Depression
_____ Addictions	_____ Diabetes
_____ Panic Attacks	_____ Sleep Disorder
_____ Colitis	_____ Speech Disorder
_____ Thyroid	_____ Eating Disorder
_____ Learning Disorder	_____ Phobias
_____ Anti-social Behaviour	_____ Language Disorder
_____ Obesity	_____ Obsessive Compulsive Disorder
_____ Seizures	_____ Anxiety
_____ ADD	_____ ADHD

Please list any other mental health issues in the family that are not listed above:

_____

_____

Medications

Please list all the medications, vitamins, etc.

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have any formal diagnosis? _____

Who made the diagnosis and at what age? _____

Have you ever had a seizure? Yes No

Are you sensitive to bright lights or strobe lights? Yes No

Do you have high or low blood pressure? Yes No

Have you ever had a head or neck injury or had a concussion? Yes No

If yes, please give details:

_____

_____

Is there anything else you would like to add, or any other issues you would like to address?

_____

_____

_____

_____

_____