NY Neurofeedback and QEEG

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INTAKE INFORMATION

NAME_____ DATE_____
BIRTHDATE_____ HANDEDNESS: L/R
CIRCUMFERENCE _____INON-NASION_____
MEDICATIONS TAKEN RECENTLY: _____
CURRENT SUPPLEMENTS: _____
History of head injuries, including sutures, concussions, and lacerations:
_____
_____
Caffeine Use: _____ Last Cigarette_____
Marijuana Use (frequency and/or last use): _____
Date&TimeofLastMeal: _____
Hours of Sleep Last Night: _____
Usual Amount of Sleep/Night: _____
Level of Alertness (10= extreme fatigue; 1= well rested, alert, and full of energy) _____
PMS? _____ Point in Menstrual Cycle:_____ Head Surgeries? _____

MEDICAL HISTORY (check all that apply): Strokes ___ Heart Attack ___ Endocrine ____
Recurrent Pulmonary ____ Chronic Pain ____ GI ____ Polio ____ HIV ____ Vascular ____
Chronic Ear Infections or Ear Tubes ____ Recurring Infections or High Fevers ____ Visual disturbances ____
Metabolic Disorders (e.g., diabetes) ____ Chemical Sensitivities ____ Thyroid ____ Allergies ___ Tinnitus__
Viral illnesses ____ Balance problems ____ Incontinence ____ Swallowing Problems _____
Do you eat fish, meat, or fowl?_____ Do you drink artificial sweeteners/diet drinks?_____ Menopausal?_____ Cravings?(sweet, sour, spicy, hot) _____
Explain any of the above that have been checked:
_____
_____
Exposure to Toxic Agents (e.g., significant exposure to heavy metals, insecticides, carbon monoxide, solvents, drug overdose, chemotherapy or radiation, etc.):_____
_____
Neurological:
Neurological Disease ____ Memory Difficulties ____ Seizures ____ Confusion ____ Restless Leg ___
Sleep Apnea or daytime drowsiness ____ Fatigue ____ Headaches or Migraines ____ Accidents _____
Coordination difficulties ____ Difficulty with balance ____ Tics Twitches, Tremor, or Parkinson's ____
Sensory Impairments (smell, hearing, seeing) ____ Fibromyalgia ____ # of times under Anesthetics ___
Complicated Birth (i.e.: forceps; fetal distress; complicated/prolonged labor, anoxia) _____
Premature birth? (Wt:) _____ Prenatal drug/alcohol exposure _____ History of Physical Abuse _____
Blows to the Head or Head injuries: _____ Loss of consciousness/Concussion? _____
Athletics (Football, boxing, soccer, lacrosse, skiing, hockey, horseback riding, martial arts) _____
Sensitivity to light & sound? _____ Total Number of Head Injuries (incl.date of) _____
Development:
Slow motor ____ Slow speech _____ Developmental delay _____ Reading/Math/Speech Problems? _____
Co-ordination Problems? _____ Academic Strengths _____
School: Below grade____ Special classes ____ Disciplinary Problem ____
Concentration/Distractibility Problems _____
Previous Psychiatric Diagnoses & TX:
Diagnosis: _____ When? _____ Were you hospitalized? _____
How Long? _____
Who made the diagnosis? _____
Current & Family History (include when & who if possible):
Depression (Rating 0-10:): _____
Anxiety (Rate 0-10 & what provokes): _____
Panic attacks (circumstances that provoke & frequency)?_____
Obsessive Rumination (what, when): _____
Delusions or Hallucinations (when, how?): _____ Fatigue (Chronic?): _____
Bipolar/Mood Swings: ___ Hx of Psychosis _____ OCD _____ Arrests ____ NAME_____

Insomnia (date of onset) _____ Frequent Awakening *(#/night:*) _____ Early Morning Awakening ____
Alcoholism _____ Substance Abuse ____ Learning Disability: _____
Anger/Irritability _____ Explosiveness ____ Impulsivity: _____
Eating Disorder: _____ Sexual Abuse: ____
PTSD (When? Who & when diagnosed?): _____
ADD (# of Criteria met) or ADHD (# of criteria met) _____
Explain any of the above checked items
_____
_____
_____

Family History of (Identify Who)
Depression and/or Suicide _____ Bipolar or Manic Depression: _____
Epilepsy: _____ Migraine: _____
Alcoholism or Drug Abuse: _____ Anxiety or Panic Attacks: _____
Tourette's (Motor or Vocal Tics): _____ ADD/ADHD: _____
Learning Disability: _____ Speech Problems: _____
Autism: _____ Schizophrenia: _____
OCD: _____ PMS: _____
Chronic Fatigue: _____ Fibromyalgia: _____
Criminal Behavior: _____ Thyroid Problems: _____
Did your mother smoke during her pregnancy with you? _____

_____ _____
Signature and Print name also Date
ALL IMPEDANCES BETWEEN: EAR IMPEDANCE LEVELS:
Look Up: Look Down: Look Right: Look Left:
Epoch H.V Begins: HV Ends:
Were there problems with drowsiness during the recording?
Was Alpha Reactive to Eye Opening?
Background: _ Normal; _ Slow; _Asymmetrical

Condition (comment on quality or any unusual circumstance)	Designation	Time
1. Eyes Closed Rest	EC1	3' _____
2. Eyes Open Rest	EO1	3' _____
3. Silent Reading Task	READ	3' _____
4. Listening Task	T2-1	3' _____
5. Math Task	MATH	3' _____
6. Social Attribution Task	T3-1	3' _____
7. Eyes Open Rest lexicor	EC2	3' _____
8. Eyes Closed Rest lexicor	EC3	3' _____
9. . Eyes Closed Rest (nose reference lead)	EC4	3' _____