Tazim Salehani, MS 214.438.0014

CHECKLIST OF CLIENT CONCERNS

NAME:

DATE: PRE/ONGOING/POST DATE:

Below is a list of items that clients frequently describe to us. Please check off any that match your current concerns. If you are not sure whether to choose an item, use the past week as a guide. Feel free to add any comments as necessary. Thank you.

Immune System
1. Allergies
2. Asthma
3. Frequent colds, infections
4. Yeast infections
5. Fatigue

Sleep
6. Difficulty falling asleep
7. Wakeful or restless during night
8. Waking up early
9. Difficulty waking up
10. Nightmares or night terrors
11. Snoring
12. Sleep walking

Skin/Hair/Nails
13. Problems with skin
14. Hair
15. Nails

Eyes
16. Double or blurred vision
17. Blind spots
18. Spots in your vision

Ear/Nose/Throat
19. Hearing loss
20. Ringing in ears
21. Earaches
22. Sense of smell changed or lost
23. Nose or sinuses blocked
24. Grinding your teeth
25. Sense of taste changed or lost
26. Hoarseness or sore throat

Heart/Lungs
27. Problems breathing
28. Heart problems
29. Hypertension
30. Palpitations
31. Dizziness

Intestines
32. Nausea or vomiting
33. Gastric pain
34. Gas or bloating
35. Irritable bowel
36. Diarrhea
37. Constipation

Hormonal/Blood
38. Appetite problems (e.g. wanting to eat when not hungry, etc)
39. Diabetes
40. Desire for sweets or carbohydrates
41. Sensitivity to heat or cold
42. Thyroid problems
43. PMS symptoms
44. Hot flashes
45. Other menopausal symptoms
46. Low interest in sex
47. Excessive interest in sex

Bones/Joints/Muscles
48. Pain or stiffness in joints or muscles
49. Sore trigger points
50. Fibromyalgia
51. Bodily fatigue

Nervous System
52. Headaches or migraines
53. Fainting
54. Seizures
55. Memory loss
56. Blocking on words
57. Reading problems
58. Difficulty speaking
59. Tremor (shaking)
60. Weakness
61. Hyperactivity
62. Problems with balance
63. Motor or vocal tics

Cognition
64. Difficulty focusing
65. Easily distracted
66. Make mistakes
67. Decision Speed
68. Memory
69. Difficulty organizing activities
70. Not completing tasks
71. Lose train of thought
72. Difficulty completing schoolwork
73. Getting into trouble at school
74. Inverting letters/numbers
75. Spatial problems (e.g. difficulty building things, understanding how things should be put together)
76. Difficulty with particular subjects

Bowel/Bladder
77. Difficulty urinating
78. Difficulty holding your urine
79. Difficulty controlling your bowels
80. Frequent bladder infections

Habits
81. Sometimes drink too much
82. Smoke cigarettes
83. Concerns about your diet
84. Desire caffeine
85. Use marijuana
86. Other addictions

Behavior/Emotions
87. Mood swings
88. Feeling down, depressed or flat
89. Feeling sad
90. Feeling anxious
91. Panic attacks
92. Worry
93. Thoughts that won't leave your mind
94. Need to repeat actions or words over and over.
95. Bingeing
96. Restricting your food intake
97. Making yourself vomit
98. Phobias- avoiding things
99. Feeling others are against you
100. Behaviors that get you into trouble, or are not good for you
101. Feeling angry a lot
102. Impulsive
103. Feeling overwhelmed
104. Feeling Lonely

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TRACKING YOUR SHIFTS

Fill this out in combination with the checklist of concerns before you start training and then every ten sessions.

NAME: _____ DATE: _____

SESSION (CIRCLE) 1 10 20 30 40

Medication I am on (how much, how often): _____

My quality of life on a scale of 0-10 is: _____

CONCERN Pick the items you circled that you would like to see shift the most. - Add any others you want to track	DURATION How long did it last? Do not count when you were sleeping	INTENSITY How strong was it 0-10	FREQUENCY How many times did you feel this way in the past week, or how many days out of 7?
1.			
2.			
3.			
4.			
5.			

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MY WISHLIST

FILL THIS OUT BEFORE YOU START YOUR TRAINING WITH NEUROPTIMAL®

I would be pleased if the following shifts were to take place in my life:

1.
2.
3.

Put this in an envelope with your Checklist of Concerns and don't look at it until after you have filled in your next set of forms!