Neurofeedback Evaluation

Child

Name:

Date:

Age:

M or F

School:

Grade:

Handedness: L R Mixed

Emotions:

Anxiety

Depression

Mood swings

Fears

Frustration

Anger

Tantrums

Obsessive worries

Self-Concept:

How child feels about self

Peers And Play:

Friends

School:

Teacher complaints

Problems with other students

Homework

Language And Thinking:

Verbal expression

Reading

Spelling

Writing

Math

Art

Sense of direction

Memory

Concentration And Organization:

Attention

Distractibility

Impulsivity

Ability to organize time and space

Activity Level And Motor Activity:

Over-active or under-active

Coordination

Accident prone

Sense of self in space

Motor tics

Vocal tics

Behavior:

Uncooperative

Inflexible

Unpredictable

Manipulative

Insensitive to others

Oppositional

Defiant

Aggressive

Values:

Lying

Cheating

Stealing

Not know right from wrong

No guilt feelings

Habits:

Sleep

Bedwetting

Nightmares or night terrors

Soiling

Teeth grinding

Eating habits

Awareness of appetite

Food sensitivities

Food cravings

Sugar craving or reaction

Compulsions

Health:

Frequent illness

Headaches

Stomachaches

Chronic constipation

Allergies

Asthma

Pain

Fainting

Seizures

Hearing problems

Vision problems

Personal History

Perinatal:

Prenatal stress or injury
Prenatal drug exposure
Difficult labor
Difficult birth
Premature or late birth
Medical problems after birth
Adopted at age _____

Growth And Development:

Colic
Sleep problems
Eating problems
Activity level
Attachment
Emotional development
Motor development
Language development
Chronic ear infections
Allergies
Asthma

Physical Traumas:

Head injury
Accidents
High fever
Serious illness
CNS infection
Drug overdose
Poisoning
Anoxia
Stroke

Psychological Traumas And Stresses:

Abuse or neglect
Family stress
School or job stress
Death in family
Illness

Treatment History

Medications:

Medication	For Condition	Dose	Dates

Medical Treatment:

Procedure	For Condition	Description	Dates

Psychological Therapy:

Therapy	For Condition	Therapist	Dates

Other Therapy:

Therapy	For Condition	Therapist	Dates

Family History

Symptom	Yes	No	Relationship
Asthma			
Autoimmune Disorders: Type 1 Diabetes, Rheumatoid Arthritis Lupus, MS, Scleroderma, etc.			
Thyroid disorder			
Migraine			
Sleep Problems			
Depression			
Manic-depression			
Anxiety			
Phobias			
Panic Attacks			
Motor or Vocal Tics			
Seizures			
Eating Disorders or Obesity			
Addictions			
Obsessive Compulsive Symptoms			
Speech Problems			
Attention Problems			
Hyperactivity			
Learning Problems			
Conduct Problems or Criminal Behavior			
Autism spectrum			
Schizophrenia			