Brain In Balance

Neurofeedback / Counselling

brainbalance.ca 778-389-3858

NEUROFEEDBACK EVALUATION - CHILD CONFIDENTIAL

PERSONAL INFORMATION Date: _____

Name: _____

Date of Birth: (day)____/(mth)____/ (yr)_____ Age: _____ M ☐ F ☐

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 _____

ATTENTION AND COGNITIVE:

☐ 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 knowing 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 _____

☐ Stomach ache _____

☐ 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 TRAU MAS:

☐ 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: 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			