**Neurofeedback Intake Form**

**Alpine Counselling Clinic Ltd**

**Complete this form and email back to info@alpinereply.ca**

|  |  |
| --- | --- |
| **First Name:** | **Last Name:** |
| **Today’s date:** | **Age:** |
| **Email:** | **Phone #:** |
|  |  |

|  |  |  |
| --- | --- | --- |
| **Please list the symptoms for which you are seeking help:**  | **How often do you****experience these** **symptoms?****Daily, every few days, once a week, occasionally.** | **On a scale from 0-10** **How distressing or** **painful are****your symptoms****0 = not at all****10 = very bad** |
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**CURRENT SITUATION**

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| --- | --- | --- |
|  |  |  |
| Are you able to drive a motor vehicle? If not please explain |  |  |
| Are you currently working? If not, please explain: |  |  |

**STAMINA & ENERGY**

|  |  |  |
| --- | --- | --- |
|  | **Times per week** | **Intensity 0 -10** |
| Not enough stamina, Fatigue during the day. |  |  |
| Wake up feeling tired. |  |  |
| Additional comments?  |  |  |

**SLEEP ISSUES**

|  |  |  |
| --- | --- | --- |
|  | **Times per week** | **Intensity 0 -10** |
| Trouble falling asleep |  |  |
| Trouble staying asleep |  |  |
| Nightmares or recurring dreams |  |  |
| Additional comments?  |  |  |

**DEPRESSION**

|  |  |  |
| --- | --- | --- |
|  | **Times per week** | **Intensity 0 -10** |
| Periods of depression |  |  |
| How long have you felt depressed? |  |  |
| Suicidal thoughts, wishes or actions |  |  |
| I think of hurting myself |  |  |
| I cry frequently |  |  |
| Additional comments? |  |  |

**ANGER**

|  |  |  |
| --- | --- | --- |
|  | **Times per week** | **Intensity 0 -10** |
| I get angry, irritable, snappy, and impatient a lot of the time |  |  |
| I have problems controlling my anger, I easily fly off the handle |  |  |
| I find it hard to calm myself down after getting upset |  |  |
| Additional comments? |  |  |

**ANXIETY**

|  |  |  |
| --- | --- | --- |
|  | **Times per week** | **Intensity 0 -10** |
| Can’t stop worrying. What do you mostly worry about? |  |  |
| Heart Palpitations, pounding, racing |  |  |
| Panic attacks |  |  |
| Fear of driving or flying |  |  |
| Feeling completely overwhelmed |  |  |
| Social anxiety: Avoiding places, people, circumstances |  |  |
| Additional comments? |  |  |

**FOCUS & CONCENTRATION**

|  |  |  |
| --- | --- | --- |
|  | **Times per week** | **Intensity 0 -10** |
| “Brain fog”, or problems with clarity |  |  |
| Problems tracking conversations, forget what you just read, just heard, what you need to do, or why you came into a room |  |  |
| Additional comments? |  |  |

**PROCRASTINATION**

|  |  |  |
| --- | --- | --- |
|  | **Times per week** | **Intensity 0 -10** |
| Problems not finishing what you start |  |  |
| Lack of motivation and initiative |  |  |
| Problems organizing your room, office or paperwork |  |  |
| IS THIS NEW FOR YOU? OR HAVE YOU ALWAYS PROCRASTINATED? |  |  |

**SENSITIVITY**

|  |  |  |
| --- | --- | --- |
|  |  **YES** | **NO** |
| Are you very sensitive to taking medication in that you respond easily with very little? |  |  |
| Can you sense smells and scents when others don’t notice? |  |  |
| Do you select people on how you feel when you are with them? |  |  |
| Can you easily sense moods and energy shifts around you? |  |  |
| Can you quickly know when something is going to work out – such as a job or a relationship? |  |  |
| When you get sick, does it take you a long time to get better. |  |  |

**REACTIVITY**

|  |  |  |
| --- | --- | --- |
|  |  **YES** | **NO** |
| Do you have strong reactions to weather changes? |  |  |
| Do you get unpleasant reactions to medications? |  |  |
| Do you have unpleasant reactions to certain smells and scents? |  |  |
| Do you have unpleasant reactions to several foods? |  |  |
| Do you have unpleasant reactions to sounds or lights? |  |  |
| Are you sometimes shocked by your own reactions? |  |  |

**RESILIENCY**

|  |  |  |
| --- | --- | --- |
|  |  **YES** | **NO** |
| Do you have good stamina and energy? |  |  |
| Can you eat any foods you want? |  |  |
| Do you generally tolerate medications without too many side effects? |  |  |
| When you get sick do you bounce back pretty quickly? |  |  |
| At the dentist, do you need more than usual amount of anaesthetics? |  |  |

**CORE 8**

|  |  |  |
| --- | --- | --- |
|  |  **YES** | **NO** |
| Do you have hearing problems - tinnitus? |  |  |
| Do you currently or ever had tics? |  |  |
| Do you get headaches or migraines? Explain |  |  |
| Do you suffer of have suffered from seizure disorders? |  |  |
| Have you ever been diagnosed with PTSD? |  |  |
| Do you suspect you might have PTSD? |  |  |
| HOW LONG HAVE THE SYMPTOMS YOU DESCRIBED IN THIS QUESTIONNAIRE BEEN HAPPENING FOR YOU? DID IT START AFTER A CERTAIN EVENT? |  |  |

**\*\*Please ONLY fill this section if you have had a CONCUSSION or a TRAUMATIC BRAIN INJURY\*\***

|  |  |  |
| --- | --- | --- |
|  | **Times per week** | **Intensity 0 -10** |
| Have you ever hit your head really hard or had a concussion or TBI? When?  |  |  |
| Dizziness |  |  |
| Nausea |  |  |
| Noise Sensitivity |  |  |
| Light Sensitivity |  |  |
| Poor balance |  |  |
| Double vision |  |  |

**DO YOU USE ANY OF THESE SUBSTANCES? Frequency per week? Amount?**

|  |  |  |
| --- | --- | --- |
| Alcohol |  |  |
| Cannabis |  |  |
| Tobacco |  |  |

**PLEASE LIST MEDICATIONS YOU CURRENTLY TAKE Purpose? How long?**

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| --- | --- |
| Are you currently, in counselling  | What type and for how long |
|  |  |

**PLEASE LIST AT LEAST 5 WAYS YOU WILL KNOW THAT YOUR SYMPTOMS HAVE REDUCED OR DISAPPEARED. BE CONCRETE ABOUT WHAT YOU WILL BE “DOING” DIFFERENTLY**

(E.G.: I will keep my desk organized, I will see my friends at least 2 times a week, go the gym again etc.)

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**Other comments:**

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