



MICRONEUROFEEDBACK ASSESSMENT

Date of assessment: ____/____/____ Date filled out. ____/____/____

Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: ____/____/____ Age: ____ Sex: ____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____. _____

Email: _____

Legal Guardian: _____

(If patient is a minor)

School/Grade: _____

(If applicable)

Occupation: _____

Emergency Contact: _____

Phone: (____) _____. _____

PERSONAL HISTORY

1. PAST AND PRESENT MEDICAL HISTORY (Please list any illness/diagnosis, physical injury, head injury – brain injury/concussion/whiplash/falls, surgeries):

PAST _____

PRESENT _____

2. MEDICATIONS (please include supplements):

| NAME | DOSE / REASON FOR TAKING |
|------|--------------------------|
| 1) | |
| 2) | |
| 3) | |
| 4) | |
| 5) | |

3. ALLERGIES (FOOD OR ENVIRONMENTAL):

| ALLERGY TO: | REACTIONS FROM EXPOSURE |
|-------------|-------------------------|
| 1) | |
| 2) | |
| 3) | |
| 4) | |
| 5) | |

4. FAMILY HISTORY (G = grandparents, P = parents, S = self):

| | | |
|---------------------|------------------|----------------------|
| Cancer G P S | Thyroid G P S | Mental illness G P S |
| Heart disease G P S | Diabetes G P S | |
| Lung disease G P S | Autoimmune G P S | |

5. SOCIAL HISTORY (Y = yes, N = never , P = past):

| | | |
|----------------|-----------------|-----------------|
| Alcohol Y N P | Antacids Y N P | Addiction Y N P |
| Smoking Y N P | Laxatives Y N P | |
| Steroids Y N P | Pain meds Y N P | |

Addiction treatment(s): _____

6. EMOTIONAL HISTORY (Y = yes, N = Never, P = past):

| | | |
|------------------|--------------------|-----------------------|
| Anxiety Y N P | Anger Y N P | Panic Y N P |
| Depression Y N P | Irritability Y N P | Abuse history Y N P |
| Insomnia Y N P | High strung Y N P | Food addiction Y N P |
| Suicidal Y N P | Fear Y N P | Eating disorder Y N P |
| PTSD Y N P | Guilt Y N P | OCD Y N P |

Additional comments:

REVIEW OF SYMPTOMS:

1. PAIN:

A. Headaches:

How often? _____

Location? _____

Severity? _____

History of Migraine headache? Yes / No

Triggers: _____

B. Body/joint/limb pain? Please describe:

Fibromyalgia? Yes / No

Photophobia (sensitivity to light)? Yes / No

Hyperacusis (sensitivity to/pain from sound)? Yes / No

What makes your pain better? _____

What makes your pain worse? _____

2. SLEEP:

Do you have difficulty falling asleep? Yes / No

Do you have difficulty staying asleep? Yes / No

How many hours do you sleep per night? _____

How many hours' sleep do you need? _____

Do you wake feeling rested? Yes / No

Nightmares? Yes / No

Additional comments:

3. FOCUS/CONCENTRATION/MEMORY:

ADD/ADHD? Yes / No

Medication / Treatment: _____

| | |
|------------------------------|----------|
| Poor concentration? | Yes / No |
| Impulsivity? | Yes / No |
| Difficulty making decisions? | Yes / No |
| Easily distracted? | Yes / No |
| Racing thoughts? | Yes / No |
| Disorganized? | Yes / No |
| Overwhelmed by stimuli? | Yes / No |

4. NEUROLOGICAL:

| | | |
|---------------------------------|----------|-----------------|
| Seizures? | Yes / No | Type: _____ |
| Stroke? | Yes / No | Location: _____ |
| Tremors? | Yes / No | |
| Traumatic Brain Injury? | Yes / No | |
| Vertigo? | Yes / No | |
| Tinnitus (ringing in the ears)? | Yes / No | |
| Hearing loss? | Yes / No | |
| Poor balance? | Yes / No | |

5. IMMUNE/ENDOCRINE/AUTONOMIC NERVOUS SYSTEM:

| | |
|----------------------------------|----------|
| Immune deficiency? | Yes / No |
| Adrenal insufficiency? | Yes / No |
| Chronic Fatigue Syndrome? | Yes / No |
| Multiple Chemical Sensitivities? | Yes / No |
| Asthma? | Yes / No |
| Irregular Menstrual Periods? | Yes / No |
| Premenstrual Syndrome (PMS)? | Yes / No |
| Menopause? | Yes / No |
| Constipation? | Yes / No |

Additional comments:

6. HOW'S YOUR GUT

Constipation? Yes No

Loose Stool? Yes No

Gas? Yes No

Bloating? Yes No

Food Sensitivities? _____

Bowel Movement at least once a day? Yes No

Any other Tummy issues _____ -

To the Best of My Knowledge the above information is correct.

_____ DATE _____

CLIENT SIGNATURE: