MicroCurrent Neurofeedback Intake

NAME _____

Birth Date_____ Age_____

Address_____

Phone_____email_____

Occupation_____

How did you hear about MC NFB?_____

Emergency Contact_____Relationship_____

Current Life Stressors

Highest Grade Completed/Degrees/Licenses

Learning Disabilities/Difficulty in School: impulsivity, disorganized, concentration, ADD/ ADHD (medication?), difficulty making decisions, easily distracted, anxiety, etc.

Summary of employment history

Military History

Trauma (birth, childhood, adulthood, concussions, etc)

Summary of Medical History

Emotional History (anxiety, depression, PTSD, fear, abuse, eating disorder, OCD, etc.,)

Alcohol, Drugs, Addictions

Marriages/Children

Family History

Family Illness—-Cancer, Heart Disease, Diabetes, Thyroid, Autoimmune, Mental Issues

Developmental Events-marriage, separation, divorce, death, loss/grief, abuse, betrayal

Describe Yourself

Describe Relationships with Friends

Describe your Strengths

Describe your Weaknesses

Prior attempts to correct problem—what have you tried previously?

List 5 main issues that you hope will be reduced or improved by MCNFB. Rate each symptom on a scale of 1 to 10 with 1 being the least (best) & 10 being the most (worst).

1._____

2._____

3._____

4._____

5._____

Medication	Dose	Purpose

List anything else that would be important to your treatment: