**Weaving Energy, LLC**

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**CHILD NEUROFEEDBACK INTAKE FORM**

**CONTACT INFORMATION**

Date:

Name:

What does your child prefer to be called?

Parent(s)/Guardian(s) Names:

Address:

City, State, Zip Code:

Who does the child live with:

Phone numbers/Phone type:

Parent email/Permission to add to email list?:

**Personal Information**

Date of Birth/Age:

Current grade in school:

School attended:

Employment:

What are your child’s challenges and successes at school/work?

**Additional Information**

Does your child regularly or easily get headaches?

Do your child’s eyes become easily tired/strained?

List prescription medications taken, indicating frequency and for what symptoms:

List vitamins, supplements, over the counter medications, topical products, herbs, etc. used:

List any chronic health conditions and the severity of symptoms (based on a scale of 0-10 where 0=no symptoms currently, 5= moderate severity, and 10=extremed severity):

List any mental health diagnosis the child has received:

Current food allergies or dietary conditions?

List other health/natural health resources you use/have used:

What do you know about neurofeedback?

**Family History**

Please share anything that you feel is relevant for the child’s immediate and extended family.  Please also include if the child has had vaccines and any patterns of disease, addiction, mental health concerns and abuse for you and/or your extended family:

**QUESTIONNAIRES**

These questionnaires are being used to gain information to assist in the neurofeedback process. They will not be used to diagnose any condition.

**GENERAL NEUROFEEDBACK QUESTIONNAIRE - PARENT**

**0 - Never 2 - Not often 5 - Sometimes 7 - Often 10 - All the time**

Next to each of the following items, type/write a number from 0 –10, using the scale above, to describe how often your child experiences these difficulties:

1. Trouble controlling anger.

2. Feeling stuck and unable to change.

3. Feeling panicky and anxious in their body.

4. Feeling helpless.

5. Feeling on edge/tense/irritable.

6. Scattered my mind and can’t focus.

7. Overreacting emotionally.

8. Procrastinating.

9. They numb, distract, and/or avoid things.

10. They ruminate about their problems.

11. They can’t make decisions.

12. They are stressed

13. Feeling like hiding rather than reaching out.

14. They are overwhelmed.

15. They are tired in their body.

16. Have symptoms of digestive problems.

17. Have pain in their body.

18. Has memory problems (indicate short or long term)

19. Repeats questions or demands over and over.

20. Has repeating/circling thoughts.

21. Take more time to think about things.

22. Has difficulty finding words.

23. Has decreased focus and/or attention.

24. Has problems with organizing.

25. Has to have things organized all the time.

26. Has problems with sequencing.

27. Has difficulty or does not finish what is started.

28. Has lost sense of direction.

29. Has lost old or familiar skills.

30. Lost the ability to remember dreams.

31. Has headaches.

32. Has nausea.

33. Has visual problems with no medical reason.

34. Has difficulty reading.

35. Has body weakness.

36. Is physically restless.

37. Is constipated.

38. Has sensory overload.

39. Experiences hallucinations.

40. Experiences flashbacks.

41. Has trouble regulating body temperature.

42. Has food preferences that have dramatically changed.

43. Is slow to react to things.

44. Has poor balance.

45. Has altered speech.

**GENERAL NEUROFEEDBACK QUESTIONNAIRE - CHILD**

**0 - Never 2 - Not often 5 - Sometimes 7 - Often 10 - All the time**

**(For young children they can answer true or false)**

Next to each of the following items, type/write a number from 0 –10, using the scale above, to describe how often you experience these difficulties:

1. I have trouble controlling anger.

2. I feel stuck and unable to change.

3. I feel panicky and anxious in my body.

4. I feel helpless.

5. I feel on edge/tense/irritable.

6. I am scattered in my mind and I can’t focus.

7. I find myself overreacting emotionally.

8. I put off doing things that need to be done.

9. I numb, distract, and/or avoid things.

10. I can’t stop thinking about my problems.

11. I can’t make decisions.

12. I am stressed

13. I feel like hiding rather than talking to or being with someone.

14. I am overwhelmed.

15. I am tired in my body.

16. I have symptoms of stomach problems.

17. I have pain in my body.

18. I have trouble remembering things

19. I repeat what I want over and over.

20. I have thoughts that don’t changer go away for a long time.

21. I take more time to think about things.

22. I have trouble finding words.

23. It is hard for me to pay attention.

24. I am not organized.

25. I have to have things organized all the time.

26. I can’t do things in the right order.

27. I do not finish the things that I start.

28. I have no sense of direction.

29. I can’t do things that I used to be able to do.

30. I never remember my dreams.

31. I have headaches.

32. I have nausea.

33. I have trouble seeing things clearly.

34. It is hard for me to read.

35. My body feels weak.

36. My body feels restless.

37. I get constipated.

38. I get overwhelmed when there is lot to see and hear at once.

39. I see or hear things that other people don’t.

40. I feel like bad memories are happening again.

41. I am too hot or too cold.

42. I don’t like the foods I did for a long time.

43. I am slow to react to things.

44. I have poor balance.

45. I have trouble speaking clearly.