TECHNOLOGIES

MCN: MICRO CURRENT NEUROFEEDBACK

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NEUROFEEDBACK ASSESSMENT

Date of assessment: ___/___/___

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

   _____

   _____

   _____

2. MEDICATIONS (please include supplements):

NAME	DOSE	REASON FOR TAKING
1)		
2)		
3)		
4)		
5)		

3. ALLERGIES (please list medication and food allergies):

MEDICATION	FOOD	REACTION
1)		
2)		
3)		
4)		
5)		
6)		

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				

Other (please describe):

_____

_____

_____

5. SOCIAL HISTORY (Y = yes, N = no, 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 = No, 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:

_____
_____
_____
_____
_____