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Neurobehavioral therapy

Date:_____

I. Intake info:

Form is completed by Parent:_____Guardian:_____
Client's Name:_____ Age:_____ Date of Birth:_____ Gender:_____
Home Address: _____
City:_____State:_____ Zip Code:_____
Mother's Name:_____ Father's Name:_____
Employer: _____ Employer: _____
Phone (Home:)_____ Phone (Home:)_____
Phone (Work):_____ Phone (Work):_____
Phone (Cell):_____ Phone (Cell):_____
E-mail Address: _____ E-mail Address: _____
Primary language spoken at home:_____
Secondary language spoken at home:_____

1.1. Insurance Information:

Insurance Company:_____Policy Holder:_____
Group Number: _____ID Number: _____
Contact Information: _____

1.2. **Reason for Seeking Support**:_____
_____
_____

1.3. Physician/other health professional (chiropractor, therapist, naturopath, bodyworker, etc.):_____
Diagnosis: _____
Current medication:_____
_____

1.4. Referral Information:

Referred By: _____
Address: _____
Telephone: _____

II. Medical history

2.1. Client's birth weight: _____lbs_____oz

Length of pregnancy:_____ Adopted at age:_____

2.2. Complications during pregnancy and or delivery:

	YES	NO	Details
Prenatal stress or injury			
Prenatal drug/alcohol exposure			
Birth trauma (forceps, breech, etc.)			
Anesthesia, pain medications			
Anoxia (oxygen deprivation @ birth			
Premature/late delivery			
Medical problems after birth			

2.3. Growth and Development

	Typical	More	Less	Details
Activity level				
Motor/coordination development				
Infections/allergies				
Emotional development				
Behavioral concerns				
Handedness development				
Appetite/digestion				
Language/speech development				

2.4. Physical Traumas

	YES	NO	Details
Head injuries (even manor falls, etc.)			
Coma (loss of consciousness)			
Accidents (list all)			
High fever			
Serious illness			
Surgery			
CNS infection			
Drug overdose/poisoning			
Recreational drug use			
Anoxia			
Stroke			

2.5. Psychological Stress/Life changes

	YES	NO	Details
Death in family			
Divorce/remarriage			
Move/relocation			
School change			
Job change			
Family member chronic illness			

III. Health/Diet

3.1. Was the client nursed? _YES/NO_ If yes, until what age?_____

Describe the client's diet:_____

_____

3.2.

	Excessive	Daily	Weekly	Rarely	Never
Vegetables					
Fruits					
Meats					
Sugar					
Artificial sweeteners					
Artificial colorings					
Dairy products					
White flour					
Tobacco					
Alcohol					

3.3.List dietary supplements and vitamins: _____

_____

_____

_____

IV. Behavior

4.1. Does the client have a history of emotional or behavioral disorders? YES/NO

Please describe_____

4.2. If there a family history of emotional or behavioral disorders? YES/NO

Please describe_____

4.3. Client's specific positive behaviors_____

4.4. Client's specific negative behaviors_____

4.5. Do you have specific behavioral goals for the client YES/NO

Please describe_____

4.6. In the table below, please indicate which of the following is a part of your child behavior:

	YES	NO	Not Sure		YES	NO	Not Sure
Distractibility				Avoidant behavior			
Short attention span				Likes competitive games			
Hyperactive				Overly sensitive			
Hypoactive (low activity level)				Difficulty following directions			
Rigid or inflexible				Difficulty with parents			
Impulsive				Difficulty with siblings			
Temper tantrums				Difficulty with teachers			
Sucks thumb				Difficulty with peers			
Few or no friends				Overly sensitive to sound			
Socially immature				Overly sensitive to touch			
Perseverating				Overly sensitive to odors			
Low frustration level				Tics			
Over-reactive				Phobias			
Destructive behavior				Emotional			
Aggressive behavior				High tolerance for pain			
Cyclical behavior: good days/bad days				Low tolerance for pain			
Cyclical academic output: good days/bad days				Compliant cooperative			
Cyclical achievement: high in some cases, but low in others)				Obedient			
Disorganized				Organized			
				Flexible social			

V. Educational History

5.1. List all schools/programs attended, grade completed and /or degree earned:

_____

_____

_____

_____

5.2. List any educational problems (Past or Current):

_____

_____

_____

_____

_____

_____

_____

5.3. List any labels, classifications, or educational diagnoses (Past or Current):

_____

_____

_____

_____

_____

_____

_____

VI. CNS Functioning Assessment

Please indicate how frequently does your child have problems in the following areas? Please pick a number from 0 to 10 ("0" means "Not at all," and "10" means "All the time").

If one or more of the parents had this, or a similar problem, place a P in the column headed by "Parents?" If the problem cames on suddenly, put an S in the column headed by "Suddenly?"

6.1. **Sensory**	*Frequency (0 - 10)*	*Parents*	*Suddenly*
Light bothers your child			
Problems with the sense of smell			
Problems with vision			
Problems with hearing			
Problems with the sense of touch			

6.2. **Emotions**	*Frequency (0 - 10)*	*Parents*	*Suddenly*
Problems of sudden, unexplained changes in mood			
Problems of sudden, unexplained fearfulness			
Problems of unexplained spells of depression			
Problems of unexplained spells of elation			
Problems with explosiveness			
Problems with irritability			
Problems with suicidal thoughts or actions			

6.3. **Clarity**	*Frequency (0 - 10)*	*Parents*	*Suddenly*
Feels "foggy" and problems with clarity			
Problems following conversations (with good hearing)			
Problems with confusion			
Problems following what he/she is reading			
Loosing what he/she has been reading			

Problems with concentration			
Problems with attention			
Problems with sequencing			
Problems with prioritizing			
Problems not finishing what he/she started			
Problems organizing his/her room, office, paperwork			
Problems with getting lost in daydreaming			
Covering up that he/she doesn't know what was said or asked of him/her			

6.4. **Energy**	*Frequency (0 - 10)*	*Parents*	*Suddenly*
Problems with stamina			
Fatigue during the day			
Trouble sleeping at night			
Problems awakening at night			
Problems falling asleep again			

6.5. **Memory**	*Frequency (0 - 10)*	*Parents*	*Suddenly*
Forget what he/she has just heard			
Forget what he/she was doing, what needs to be done			
Problems with procrastination and lack of initiative			
Problems not learning from experience			

6.6. **Movement**	*Frequency (0 - 10)*	*Parents*	*Suddenly*
Problems with paralysis of one or more limbs			
Problems focusing or converging the eyes			

6.7. **Pain**	*Frequency (0 - 10)*	*Parents*	*Suddenly*
Head pain that is steady			
Head pain that is throbbing			
Shoulder and neck pain			

Wrist pain			
Knee pain			
All-over pain			
Joint pain			
Other pain (specify)			

6.8. **Other Problems**	*Frequency (0 - 10)*	*Parents*	*Suddenly*
Problems with nausea			
Skin problems			
Problems with speech or articulation			
Dizziness			
Noise in ears (Tinnitus)			

VII. qEEG questionnaire

The following items will help to quantify some of the important issues and concern related to your child assessment and treatment. Please provide your best estimate of how you think your child is now.

Indicate your assessment by assigning a number from 1 to 5 according to the following scale:

5=Very true; 4=Mostly true; 3=Somewhat true; 2=Rarely true; 1=Not true

1. ___My child is easy to anger
2. ___ My child is stubborn
3. ___ My child is depressed
4. ___ My child is very anxious
5. ___ My child is very artistic
6. ___ My child feels tired and fatigued
7. ___ My child checks things over and over
8. ___ My child does unwanted things because he/she cannot resist doing them
9. ___ My child feels tired and fatigued much of the time
10. ___ My child is a perfectionist
11. ___ My child is too willing to please others
12. ___ People like my child
13. ___ My child is easily frightened
14. ___Sometimes my child cannot get rid of annoying or disturbing thoughts
15. ___ My child laughs a lot
16. ___ My child flies off the handle
17. ___ My child feels worthless
18. ___In disagreements it is my child's way or no way
19. ___ My child feels like he/she does not have much to look forward to
20. ___It is hard for my child to concentrate
21. ___ My child often does not remember what he/she has just read
22. ___ My child is forgetful
23. ___ My child is often physically unwell
24. ___ My child has a positive emotional life
25. ___ My child has sleep problems
26. ___ My child feels restless and cannot sit still
27. ___ My child is easily annoyed or irritated