NEURO DYNAMIX

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Neurofeedback Evaluation
Child

Name:	
Date:	
Age:	
M or F:	
School:	
Grade:	
Handedness:	L R Mixed

Emotions

Anxiety

Depression

Mood swings

Fears

Frustration

Anger

Tantrums

Obsessive worries

Self - concept

How child feels about self

Peers and play

Friends

School

Teacher complaints

Problems with other students

Homework

Language and thinking

Verbal expression

Reading

Spelling

Writing

Math

Art

Sense of direction

Memory

Concentration and Organization

Attention span

Distractibility

Impulsivity

Ability to organize time and space

Activity and motor activity

Over-active or under-active

Coordination

Accident prone

Sense of self in space

Motor tics

Vocal tics

Behavior

Uncooperative

Inflexible

Unpredictable

Manipulative

Insensitive to others

Oppositional

Defiant

Aggressive

Values

Lying

Cheating

Stealing

Not know right from wrong

No guilt feelings

Habits

Sleep

Bedwetting

Nightmares or night terrors

Soiling

Teeth grinding

Eating habits

Awareness of appetite

Food sensitivities

Food cravings

Sugar craving or reaction

Compulsions

Health

Frequent illness

Headaches

Stomachaches

Chronic constipation

Allergies

Asthma

Pain

Fainting

Seizures

Hearing problems

Vision problems

Personal History

Perinatal

Prenatal stress or injury

Prenatal drug exposure

Difficult labor

Difficult birth

Premature or late birth

Medical problems after birth

Adopted at age _____

Growth and Development

Colic

Sleep problems

Eating problems

Activity level

Attachment

Emotional development

Motor development

Language development

Chronic ear infections

Allergies

Asthma

Physical Traumas

Head injury

Accidents

High fever

Serious illness

CNS infection

Drug overdose

Poisoning

Anorexia

Stroke

Psychological Traumas and Stresses

Abuse or neglect

Family stress

School or job stress

Death in family

Illness

Treatment History

Medications:

Medication	For Condition	Dose	Dates

Medical Treatment:

Procedure	For Condition	Description	Dates

Psychological Therapy:

Therapy	For Condition	Therapist	Dates

Medications:

Medication	For Condition	Dose	Dates

Family History

Symptom	Yes	No	Relationship
Asthma			
Autoimmune Disorders: Type 1 diabetes, Rheumatoid Arthritis, Lupus, MS, Scleroderma etc.			
Thyroid disorder			
Migraine			
Sleep problems			
Depression			
Manic-depression			
Anxiety			
Phobias			
Panic attacks			
Motor or vocal tics			
Seizures			
Eating disorders or obesity			
Addictions			
Obsessive compulsive symptoms			
Speech problems			
Attention problems			
Hyperactivity			
Learning problems			
Conduct problems / criminal behavior			
Autism spectrum			
Schizophrenia			