LEIGH BRAIN & SPINE
Providing Solutions. Changing Lives.

Adult Brain Functioning Assessment Form

Please fill out the attached forms. The more we know about you, the better we can choose appropriate treatment programs and protocols. It helps to know if any past abuse and drug use, but if any questions make you uncomfortable you may leave them blank.

Leigh Brain & Spine

Brain Functioning Assessment Questionnaire

Name: _____ Age: _____ Birthday: ____/____/_____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

School: _____

Occupation: _____ How Long: _____

Guardian Name(s):_____

Email: _____

Sex*: M F Other	Handedness: R L Mixed	Blood Pressure:

*Please indicate sex at birth. If you feel comfortable documenting transitions and/or additional information, please do so in the "History" section of this form.

How did you hear about our office? _____

Presenting Challenge(s):

It is important to know whether you have any of these symptoms presently or have ever had them. Please check all that apply.

ATTENTION SYMPTOMS

	ADD (inattentive subtype)
	Inattention (internal)
	Daydreaming
	Poor Concentration
	Lack of Motivation
	Impulsivity
	Distractibility (external)
	Stimulus Seeking

	Thrill seeking
	Competing thoughts; too many thoughts
	ADHD (Attention Deficit/ Hyperactivity Disorder)
	Hyperactivity after sugar
	Hyperactivity after sedatives
	Overwhelmed by stimuli
	Hard to make decisions (executive function)
	Disorganized

SLEEP SYMPTOMS

	Night sweats
	Frequent waking during night (without agitation)
	Sleep lightly
	Sleeping too much
	Sleep apnea
	Snoring
	Not rested after sleep
	Waking early
	Difficulty falling asleep (mind quiet)
	Difficulty falling asleep- mind busy
	Physically restless sleep
	Nightmares (bad dreams)
	Bruxism (teeth grinding)

	Restless leg syndrome
	Vivid dreams
	Clenching jaw
	Waking with agitation
	Night terrors—w/screaming, don't remember in morning
	Nocturnal myoclonus (jerking, moving while sleeping)
	Sleep walking
	Sleep talking
	Narcolepsy (falling asleep frequently and/or suddenly)
	Too busy to sleep (manic)
	Night sweats (hypoglycemic)
	Enuresis (bed wetting)

How long does it take for you to fall asleep? _____

How many hours of sleep do you get a night? _____

What time do you go to sleep? _____

What time do you get up? _____

EMOTIONAL AND BEHAVIORAL SYMPTOMS

	Anxiety (Worry)
	Depression (Helpless & Hopeless
	Irritability
	Feelings easily hurt
	Perfectionist
	Remorseful after tantrums
	Cries easily (feelings hurt)
	Guilt
	Withdraws when stressed
	Passive
	Wishes was dead
	Grumpy
	Thinks little of self
	Performance anxiety
	Shy
	Seasonal Affective Disorder
	Fidgets
	Whining
	High pain threshold
	Loud, unmodulated voice
	Poor eye contact
	Poor social awareness
	Autistic symptoms
	Motor or vocal tics
	Road rage
	Nail biting, nervous habits
	Attachment disorder(history)
	Anxiety (Fear)
	Depression (Agitated)
	Agitation
	Mania
	Paranoia

	Suicidal thoughts or actions
	Shame
	Compulsive behavior
	Obsessive thoughts
	Involuntary movement or tics
	Impatient
	Aggressive-Initiates conflicts
	Jealous/envious
	Angry
	Rumination
	Hates self
	Dissociative
	Lacks empathy
	Lacks cause and effect thinking
	Manipulative, controlling
	Hold a grudge
	Poor comprehension and expression of emotions
	Lack of body awareness, (pain, discomfort)
	Binge Eating
	Anorexia
	Bulimia
	Bipolar (Manic-depressive cycles)
	Panic attacks
	Encopresis (soiling)
	IBS (Irritable Bowel Syndrome)
	Dissociative Identity Disorder (Multiple Personality)
	Borderline Personality Disorder
	Post-Traumatic Stress Disorder (PTSD)
	Rages

COGNITIVE SYMPTOMS

	Dyslexia
	Poor word fluency
	Poor sequential processing
	Poor sequential planning
	Poor reading comprehension
	Difficulty decoding words
	Poor arithmetic calculation
	Indecisive
	Non-verbal learning disabilities
	Poor visual-spatial skills

	Poor sense of self in space
	Poor drawing
	Inability to write neatly (even slowly)
	Poor fine motor skills
	Poor math concepts
	Poor spelling
	Poor tracking during reading
	Lack of prosody in speech (monotone speech)
	Poor sense of direction
	Don't know left and right

PAIN SYMPTOMS

	Chronic pain with depression
	Chronic aching pain
	Tension headache
	Low pain threshold
	Fibromyalgia
	RSD (Reflex Sympathetic Dystrophy
	Migraine
	Jaw tension

	Chronic burning pain
	Chronic throbbing pain
	Chronic stabbing pain
	Chronic shooting pain
	Sciatica pain
	High pain threshold
	Peripheral neuropathy pain
	Emotional reactivity to pain

NEUROLOGICAL AND MOTOR SYMPTOMS

	Left-brain partial seizures
	Left-brain TBI (traumatic brain injury)
	Right body paralysis or paresis
	Enuresis (urinary incontinence)
	Generalized seizures
	Absence (petit mal) seizures
	Tonic-clonic (grand mal) seizures
	TBI with brain stem injury
	Vertigo
	Tinnitus

	Right-brain partial seizures
	Right-brain TBI
	Left body paralysis
	Spasticity
	Tremor
	Poor balance
	Poor coordination
	Involuntary regurgitation
	Tics
	Nervous habits/laugh
	Reflux

SENSORY INTEGRATION

Do tags on shirts, seams on socks, or certain fabric textures bother you? _____

Are you more sensitive to the environment than others? _____

Unusual sensitivity to light or certain smells? _____

Are you clumsy or accident-prone? _____

IMMUNE, ENDOCRINE & ANS SYMPTOMS

	Sugar craving (hypoglycemia)
	Immune deficiency
	Low thyroid function
	PMS - depressive symptoms
	Irritability
	Mood swings
	Insomnia
	Sugar craving
	Migraines
	Pain
	Cramps
	Intolerant of alcohol, other sedatives
	Irregular menstrual periods
	PMS
	Mania, rage, agitation
	Racing thoughts
	Skin allergies - eczema
	Heart palpitations

	Constipation
	Intolerant of coffee, other stimulants
	Hypertension
	Hypotension
	Incontinence
	Severe PMS (mood swings, migraine)
	Chronic fatigue syndrome
	Irritable bowel syndrome
	Autoimmune disorders:
	Type I diabetes
	Lupus
	Rheumatoid Arthritis
	Crohn's Disease
	Multiple Sclerosis
	Asthma
	Multiple chemical sensitivities

HISTORY

Prenatal, birth events, and/or injuries such as stress, injury, drug exposure, difficult labor, forceps delivery, breech birth, induced labor, pitocin, anesthesia, anoxia, premature/late delivery, or post-birth problems? Other? Please describe.

Problems with growth and development such as severe or recurrent illnesses or infections, allergies, emotional difficulties, behavioral problems, appetite/digestion, language/speech, coordination? Walking or talking early? Walking or talking late? History of ear infections? Please describe.

Physical trauma, injury, coma, accidents, high fever, serious illness, surgery, CNS infection, poisoning, anoxia, stroke, heart attack? Have you ever been to the Emergency Room? Please describe.

Recreational drug use? If so, when, what drugs and how did each impact you? Have you ever had a drug overdose?

Psychological stresses/life changes, especially during childhood such as a death, divorce, loss, move, school change, job change, illness? Have you experienced emotional, physical or sexual abuse or neglect? Please describe.

Currently or recently on any medications, drugs, hormone replacements, allergy or asthma treatments, alternative therapies, nasal sprays? Other? Please list name, dosage and indication for use:

Surgeries, hospitalizations, or medical treatments? Was either general or local anesthesia used? Please describe.

Are you currently under treatment or supervision by a health provider? For what condition(s)? Who is your primary health provider?

Any psychological therapies (psychologist, social worker, family therapist)? Are you currently in psychotherapy? If so, with whom? Have you ever been given a psychiatric diagnosis?

Any educational therapies (tutors, special schools, resource teacher, vision therapy, etc.)? Please describe.

Any neurological or educational testing? Do you have copies of these tests or the results?

Have any close relatives experienced epilepsy, autism, Asperger's, alcoholism, mental illness, depression, suicide, incarceration or anything else reviewed in this assessment? Please describe.

LIFESTYLE INVENTORY:

Do you drink alcohol?	If so, how often?	How much?
Do you drink caffeine?	If so, how often?	How much and what time of day?
Do you smoke cigarettes/vape?	If so, how much per day?	How long have you smoked?
Do you use supplements?	If so, which ones?	How often?
How many hours do you watch TV per day?	On weekdays?	On weekends?
Do you play computer games?	How many hours per weekday?	How many hours per weekend?
Read for pleasure?	How many hours per weekday?	How many hours per weekend?
Exercise?	What forms?	How often?
What do you do to relax?	How many hours per weekday?	How many hours per weekend?

Please list the top 3 goals that you would like to accomplish through Neurofeedback training in the order of importance to you. Please describe below.

1.

_____

_____

_____

_____

2.

_____

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3.

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