The Brain Gym
111 East 3rd Street
Suite 213B
Rifle, CO. 81650
970-665-9956

MICROCURRENT NEUROFEEDBACK ASSESSMENT

Date of assessment: _____/_____/_____ Date filled out. _____/_____/_____

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

PAST:_____
_____
_____
_____

PRESENT:_____
_____
_____
_____

2. MEDICATIONS (please include supplements):

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

3. ALLERGIES (FOOD OR ENVIRONMENTAL):

ALLERGY TO:	REACTIONS FROM EXPOSURE
1)	
2)	
3)	
4)	
5)	

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	

5. SOCIAL HISTORY (Y = yes, N = never , 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 = Never, 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

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<u>REVIEW OF SYMPTOMS:</u>
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	Stroke?	Yes / No
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

Constipation? Yes / No Multiple Chemical Sensitivities? Yes / No

Asthma? Yes / No Irregular Menstrual Periods? Yes / No

Menopause? Yes / No Premenstrual Syndrome (PMS)? Yes / No

Chronic Fatigue Syndrome? Yes / No

Additional comments:

_____

_____

_____

6. GUT HEALTH:

Constipation? Yes / No Loose Stool? Yes / No

Gas? Yes / No Bloating? Yes / No

Food Sensitivities?_____

Bowel Movement at least once a day? Yes / No

Any other Stomach/Digestion Issues:

_____

_____

_____

_____

7. ELECTRO CONVULSIVE THERAPY:

Have you ever had ECT? Yes / No

8. PRE-SESSION PREPERATION:

Please know that if you are currently taking medications, these may affect the progress of your treatment.

Come into your sessions without lotions or substances on your skin on your face, neck and forehead.

Do not plan to have any other treatments such as massage, dental work, chiropractic work, or therapy sessions on the same day as your MCN treatment.

Know that drinking alcohol the day of your treatment can also hinder progress and avoid drinking on the day of your treatment.

To the Best of My Knowledge the above information is correct.

*Where did you hear about The Brain Gym?*_____

SIGNATURE: _____ Date: _____

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