

CLIENT INFORMATION

Client's Name		Date	
Address		Age	
Contact Numbers		Sex	
Home		DOB	
Office			
Cell			
Email Address:			

FOR ADULTS and/or PARENTS:

Occupation		Soc.Sec.#	
Employer			
Bus. Address			
Bus. Telephone			
Spouse/Name			
Occupation			
Bus. Address			
Bus. Telephone			

FOR CHILDREN:

School		Grade	
Teacher's Name			
Father's Name		Soc.Sec.#	
Employer		Occupation	
Bus. Address		Bus. Phone	
Mother's Name		Soc.Sec.#	
Employer		Occupation	
Bus. Address		Bus. Phone	

What concern brought you to our Center?

Who referred you to our Center?

Informed Consent and Authorization

Brain Boosters' "Brain Efficiency Training" is to be understood in the context of a learning activity. The computer hardware and software act as a personal tutor. The individual that participates in the training does so as a student that is being taught. The subject that is taught and learned is "brain efficiency". In the training activity, sensors on the scalp read the student's EEG Electroencephalograph. This measurement is an indicator of how the student is using their mental energy. The computer/ software (tutor) uses the EEG to determine when the student's brain is functioning at "peak efficiency" and then feeds back visual and auditory cues that the student's brain uses as a guide to learning and practicing being efficient with mental energy usage. The training is non-invasive and is not to be considered as a medical procedure or treatment. It is simply a training exercise. The benefits that are received from the training are seen as a direct result of improved mental function. Within our model, we see the improvement as a direct result of building better brain energy reserves which facilitate improved sleep performance and sleep quality. I have read the above statements, I understand them and agree to proceed with the Brain Efficiency Tutoring based on this understanding.

Signature: _____ Date: _____

CLIENT SYMPTOM SURVEY

Name _____

Date _____

<i>Under the following categories, please circle the number which best describes the frequency of symptoms.</i>				
<i>0 = Never (not seen)</i>	<i>1 = Mild (slight)</i>	<i>2 = Moderate (considerable)</i>	<i>3 = Severe (extreme)</i>	
SLEEP			BEHAVIOR	
Insomnia	0	1	2	3
Difficulty falling asleep	0	1	2	3
Difficulty maintaining sleep	0	1	2	3
Difficulty waking	0	1	2	3
Nightmares or vivid dreams	0	1	2	3
Night terrors	0	1	2	3
Restless sleep	0	1	2	3
Snoring	0	1	2	3
Sleep apnea	0	1	2	3
Teeth grinding in sleep (Bruxism)	0	1	2	3
Sleep walking	0	1	2	3
Talking during sleep	0	1	2	3
Night sweats	0	1	2	3
Narcolepsy	0	1	2	3
Restless leg	0	1	2	3
Bedwetting	0	1	2	3
Irregular sleep cycle	0	1	2	3
ATTENTION & LEARNING			Can listen to music & study at same time	
Poor short term memory	0	1	2	3
Difficulty remembering names, faces, dates	0	1	2	3
Makes lists to remember	0	1	2	3
Makes repeated mistakes	0	1	2	3
Absent-minded, forgetful	0	1	2	3
Easily distracted	0	1	2	3
Unmotivated	0	1	2	3
Difficulty completing tasks	0	1	2	3
Difficulty thinking clearly	0	1	2	3
Difficulty making decisions	0	1	2	3
Procrastinates	0	1	2	3
Poor vocabulary	0	1	2	3
Messy handwriting	0	1	2	3
Poor drawing ability	0	1	2	3
Poor math skills	0	1	2	3
Difficulty remembering math facts	0	1	2	3
Reading difficulty	0	1	2	3
Not listening	0	1	2	3
Lacking common sense	0	1	2	3
Slow thinking (things don't "sink in")	0	1	2	3
Lack of alertness	0	1	2	3
Difficulty shifting tasks	0	1	2	3
Poor concentration	0	1	2	3
Poor sustained attention	0	1	2	3
Difficulty shifting attention	0	1	2	3
Difficulty understanding conversations	0	1	2	3
Mixing or reversing letters or numbers	0	1	2	3
Difficulty organizing personal time or space	0	1	2	3
Poor word finding	0	1	2	3
			Stuttering, stammering	
			Poor speech articulation	
			Impulsive or unpredictable	
			Motor or vocal tics	
			Hyperactive, restless, or fidgety	
			Physically aggressive at times	
			Difficulty getting along with peers	
			Poor eye contact	
			Nail biting	
			Eating disorders	
			Argumentative	
			Tantrums or rages (gets upset easily)	
			Addictive behaviors	
			Compulsive behaviors	
			Manipulative behavior	
			Aggressive behavior	
			Oppositional or defiant disorders	
			Excessive talking	
			Poor grooming	
			Lack of appetite awareness	
			Lack of sense of humor	
			PEERS AND PLAY	
			Difficulty maintaining friendships	
			Very controlling	
			Invades others personal space	
			Gets into fights with others	
			Insensitive to the needs of others	
			LANGUAGE	
			Difficulty expressing self verbally	
			Difficulty reading	
			Difficulty expressing self in writing	
			Struggles with math	
			Difficulty understanding verbal instructions	
			Difficulty comprehending what is read	
			Difficulty reading book from cover to cover	
			Dyslexia	
			Difficulty with Spelling	

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<i>0 = Never (not seen)</i>	<i>1 = Mild (slight)</i>	<i>2 = Moderate (considerable)</i>	<i>3 = Severe (extreme)</i>	
EMOTION			PHYSICAL	
Agitation	0 1 2 3	0 1 2 3	Low muscle tone	0 1 2 3
Irritability	0 1 2 3	0 1 2 3	Spasticity	0 1 2 3
Mood swings	0 1 2 3	0 1 2 3	Chronic constipation	0 1 2 3
Fears or phobias	0 1 2 3	0 1 2 3	Irritable bowel	0 1 2 3
Depression	0 1 2 3	0 1 2 3	Seizures	0 1 2 3
Impatience	0 1 2 3	0 1 2 3	Poor fine motor coordination	0 1 2 3
Crying	0 1 2 3	0 1 2 3	Poor gross motor coordination	0 1 2 3
Anxiety (seems anxious for nothing)	0 1 2 3	0 1 2 3	PMS symptoms	0 1 2 3
Short Temper, lots of anger inside	0 1 2 3	0 1 2 3	Immune deficiency	0 1 2 3
Feels or appears "stressed out"	0 1 2 3	0 1 2 3	Tachycardia	0 1 2 3
Emotional Reactivity	0 1 2 3	0 1 2 3	Heart palpitations	0 1 2 3
Low self-esteem	0 1 2 3	0 1 2 3	Acid reflux	0 1 2 3
Lack of social interest	0 1 2 3	0 1 2 3	High blood pressure	0 1 2 3
Panic attacks	0 1 2 3	0 1 2 3	Rigidity	0 1 2 3
Anger	0 1 2 3	0 1 2 3	Tremor	0 1 2 3
Suicidal thoughts	0 1 2 3	0 1 2 3	Nervous stomach	0 1 2 3
Lack of pleasure	0 1 2 3	0 1 2 3	Fatigue	0 1 2 3
Obsessive negative thoughts or worries	0 1 2 3	0 1 2 3	Asthma	0 1 2 3
Difficult to soothe	0 1 2 3	0 1 2 3	Sugar craving and reactivity	0 1 2 3
Paranoia	0 1 2 3	0 1 2 3	Allergies	0 1 2 3
Mania	0 1 2 3	0 1 2 3	Frequent stomach aches	0 1 2 3
			Muscle tension	0 1 2 3
BALANCE & COORDINATION			Diabetes	Yes No
Poor balance	0 1 2 3	0 1 2 3	Muscle weakness	0 1 2 3
Accident Prone	0 1 2 3	0 1 2 3	Hot flashes	0 1 2 3
Uncoordinated or clumsy	0 1 2 3	0 1 2 3	Urge incontinence	0 1 2 3
Shaking or tremors	0 1 2 3	0 1 2 3	Sweating	0 1 2 3
Difficulty with fine motor tasks, such as tying shoes, buttons, or zipper	0 1 2 3	0 1 2 3	Nausea	0 1 2 3
Difficulty riding a bike, skating, jump rope	0 1 2 3	0 1 2 3	Stress incontinence	0 1 2 3
Bumps into things, trips, falls	0 1 2 3	0 1 2 3	Effort fatigue	0 1 2 3
			Encopresis (incontinence of bowel)	0 1 2 3
			Clumsiness	0 1 2 3
PAIN			Difficulty walking or moving	0 1 2 3
Chronic aching pain	0 1 2 3	0 1 2 3	Cerebral Palsy	0 1 2 3
Migraine pain	0 1 2 3	0 1 2 3	Difficulty working	0 1 2 3
Muscle tension pain	0 1 2 3	0 1 2 3	Asperger's Syndrome	Yes No
Trigeminal neuralgia	0 1 2 3	0 1 2 3	Autism	Yes No
Sciatica	0 1 2 3	0 1 2 3	A.D.D. (Attention Deficit Disorder)	0 1 2 3
Fibromyalgia	0 1 2 3	0 1 2 3	P.D.D. (Pervasive Developmental Disorder)	0 1 2 3
Chronic nerve pain	0 1 2 3	0 1 2 3	Dyslexia	0 1 2 3
Stomach ache	0 1 2 3	0 1 2 3	A.D.H.D. (Attn Deficit Hyperactivity Disorder)	0 1 2 3
Joint pain	0 1 2 3	0 1 2 3	Restless Leg (other than in sleep)	0 1 2 3
Muscle pain	0 1 2 3	0 1 2 3	Down's Syndrome	Yes No
Jaw pain	0 1 2 3	0 1 2 3	M.S. (Multiple Sclerosis)	0 1 2 3
Abdominal pain	0 1 2 3	0 1 2 3	Migraine	0 1 2 3
Sinus pain	0 1 2 3	0 1 2 3	Other (please describe)	0 1 2 3

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SENSORY			GROWTH & DEVELOPMENT		
Sensitive to lights	0	1	2	3	At what age did the child begin walking?
Hypersensitive to sounds	0	1	2	3	
Sensitivity to touch from others	0	1	2	3	Did he/she crawl before walking?
Very sensitive to feel of clothes, seams, tags	0	1	2	3	
Tinnitus - ringing in the ears	0	1	2	3	At what age was speech onset?
Sensitivity to the smell of foods, perfumes	0	1	2	3	
Chemical sensitivities	0	1	2	3	Difficulty with speech?
Motion sickness (car or amusement rides)	0	1	2	3	
Poor body awareness	0	1	2	3	Had colic as a baby?
Fascinated with certain objects	0	1	2	3	
Over or under sensitivity to pain	0	1	2	3	Chronic ear infections?
Loves to spin objects or self spin	0	1	2	3	
Vertigo (Dizzy Spells)	0	1	2	3	Known Learning Disabilities?
Difficulty remembering right from left	0	1	2	3	
Needs directions for somewhere you've been	0	1	2	3	Been assigned Special Ed Class?
Easily disoriented	0	1	2	3	
Difficulty telling time on a regular clock	0	1	2	3	Number of Children in Family?
Has no concept of time	0	1	2	3	
Difficulty being on time	0	1	2	3	This child is number _____.
Difficulty judging elapsed time	0	1	2	3	
Tilts head when reading	0	1	2	3	Have you sought treatment elsewhere?
Loses place easily - skips words, lines	0	1	2	3	
Poor depth perception	0	1	2	3	
Limited peripheral vision, tunnel vision	0	1	2	3	PHYSICAL TRAUMAS
					Head injury
VALUES					Accidents
Tells lies frequently	0	1	2	3	High Fever
Cheats on schoolwork or at playing games	0	1	2	3	Serious Illness
Incidents of stealing, steals from others	0	1	2	3	CNS Infection (Central Nervous System)
Doesn't seem to know right from wrong	0	1	2	3	Drug Overdose
Doesn't feel guilty when caught doing wrong	0	1	2	3	Poisoning
					Anoxia
PERINATAL					Stroke
Difficult labor	0	1	2	3	
Oxygen deprivation at birth	0	1	2	3	PSYCHOLOGICAL TRAUMAS
Prenatal drug or alcohol exposure	0	1	2	3	Abuse or neglect
Difficult birth	0	1	2	3	Family Stress
Premature	0	1	2	3	School or Job Stress
Pneumonia or sepsis (infection)	0	1	2	3	Death in Family
Hyperbilirubinemia / Jaundice	0	1	2	3	Illness
Adopted Yes _____ No _____					
ADDITIONAL NOTES:					
How many hours of Video Game playing per day / week?					

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EMOTIONAL SYMPTOMS			
<i>Please mark "Yes" or "No" for all of the following Emotional Symptoms which apply.</i>			
SYMPTOM	Yes	No	
Irrational or out of control behavior patterns			
Compulsive Disorders - Often Obsessive			
Signs of Perfectionism			
Impulsive / Doesn't think of consequences			
Gets into trouble often			
Very impatient with others			
Short temper/lots of anger/outbursts of anger			
Poor self image - low self esteem			
Frequent Headaches			
Frequent stomach aches / nervous stomach			
Uncoordinated or clumsy			
Occasional dizzy spells - Balance disorders			
Chronic Fatigue Syndrome - tires easily			
Visual stress like eye fatigue - eye strain			
Lots of Stress concerning school or work			
Difficulty taking tests			
Difficulty managing stress			
Tension			
Frustration			
Feelings like you can't cope / overwhelmed			
Irritability - getting upset easily			
Depression			
Frequent Moodiness - mood swings			
Panic / Anxiety attacks			
Irrational fears			
Crying jags			
Phobias			
Feelings of Disorientation / Forgetfulness			
Always writing notes			
Poor short term memory			
Can't remember names or phone numbers			
Poor retention			
Seems to withdraw from people			
Enjoys being alone			
Insomnia / Sleep disorders			
Nightmares			
Night terrors			
Sleep walking			
Procrastination / Can't make decisions easily			
Difficulty maintaining long-term relationships			
Few close friends			
Please sign below to acknowledge all above information on Pages 1-6 to be true to the best of your knowledge.			
Signature:		Date:	
<i>(circle one: Self Parent/Guardian)</i>			

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BEHAVIOR RATING SCALE		
Rate EVERY statement by placing the appropriate number which most fits the behavior on the line next to the statement.		
0	-	Haven't noticed this behavior
1	-	Noticed this behavior to a SLIGHT degree
2	-	Noticed this behavior to a CONSIDERABLE degree
3	-	Noticed this behavior to a LARGE degree
4	-	Noticed this behavior to an EXTREME degree
ATTENTION		
		Does not finish assigned tasks _____
		Fails to complete what he/she starts (book, puzzle) _____
		Does not seem to listen or pay attention _____
		Trouble concentrating on work or other tasks _____
		Has difficulty sticking to just one activity _____
		Is easily distracted when listening to instructions _____
		Hears well but usually asks to have things repeated _____
		Cannot remember what must be done right now _____
TOTAL SCORES FOR ATTENTION		<input style="width: 50px; height: 20px;" type="text"/>
IMPULSIVITY		
		Often acts before thinking _____
		Shifts excessively from one activity to another _____
		Has difficulty organizing work _____
		Often interrupts or speaks out of turn _____
		Talks excessively or makes noises constantly _____
		Extremely excitable around other people _____
		Procrastinates endlessly _____
TOTAL SCORES FOR IMPULSIVITY		<input style="width: 50px; height: 20px;" type="text"/>
ACTIVITY		
		Is always on the go - Cannot sit still _____
		Has difficulty sitting still or fidgets excessively _____
		Moves excessively during sleep _____
		Has difficulty staying seated _____
		On the go much of the time, in perpetual motion _____
		Fidgets or squirms when doing desk work _____
		Usually does things in a loud or noisy way _____
		Must always be doing something with hands/feet _____
TOTAL SCORES FOR ACTIVITY		<input style="width: 50px; height: 20px;" type="text"/>

CLIENT SYMPTOM SURVEY

Name

Date

NOTES

Lined area for notes.