

# 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

Distractibility

Impulsivity

Ability to organize time and space

**ACTIVITY LEVEL 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  
Anoxia  
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

### OTHER THERAPY:

Therapy	For Condition	Therapist	Dates

## FAMILY HISTORY

Symptom	Yes	No	Relationship
Asthma			
Autoimmune Disorders: I 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 or Criminal Behavior			
Autism spectrum			
Schizophrenia			

