Seacoast Neurofeedback, LLC

Initial Assessment

Name: _____

Address:_____

Date: ____/____/_____

Date of Birth: ____/____/_____

Phone: ( )-

Email: _____

File # (office use): _____

1. **How did you hear about the Low Energy Neurofeedback System or the LENS?:**

2. **What is your biggest concern?:**

3. **How long has that been an issue for you?:**

4. **What other modalities have you tried?:**

   a.

   b.

   c.

   d.

5. **What has worked for you in the past, if anything? When did it stop working?:**

6. **What do you hope to gain with the LENS?:**

7. **Are you currently seeing anyone else for this issue?:**

8. List of current practitioners:

a. _____

b. _____

9. Medications:

c. _____ How long _____

d. _____ How long _____

e. _____ How long _____

f. _____ How long _____

Are you stable on your medications in that your provider isn't making any adjustments? Yes _____ No _____

10. Other Medical Diagnoses:

a. _____

b. _____

c. _____

d._____

11. Any of the following:

a. Dysbiosis or is your intestinal bacteria out of balance: Yes _____ No _____

b. Lyme Disease: Yes _____ No _____

c. Hep C: Yes _____ No _____

d. HIV. Answering is voluntary: Yes _____ No _____

e. Leaky Gut Syndrome: Yes _____ No _____

f. Heavy Metals Exposure: Yes _____ No _____

g. Chronic exposure to mold: Yes _____ No _____

h. Anxiety: Yes _____ No _____

i. Depression: Yes _____ No _____

j. Probiotic: Yes _____ No_____

k. Cancer diagnosis Yes _____ No _____
If yes, where _____

l. Any of the following: Seizure ___ Migraine___ cluster headache___ headache___ Tourette's Syndrome___ Explosiveness___ tics___ stuttering___

12. What is your diet like:

a. Primarily plant based _____

b. Meat & Potatoes _____

c. Dairy Yes _____ No _____

d. Gluten Free _____

e. Pescatarian (fish) _____

f. Ovolacto vegetarian (eggs & dairy): _____
g. Adequate hydration before session _____

13. Mental, Emotional Health history. Seizure disorder, etc.

a. Bipolar disorder _____

b. Schizophrenia _____

c. Seizure disorder _____

d. Other mental health diagnosis _____

14. Are you pregnant? Yes _____ No _____

Planning to get pregnant? Yes_____ No _____

You agree to notify the LENS practitioner immediately if you become pregnant. Yes _____

15. How will you know when you're done?

16. Work/Profession: _____