Neurofeedback Pre-Screener Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

BASIC INFORMATION

Name: ____
(Last) (First) (Middle Initial)

Age: __________ Gender: ________________

Home Phone: ( ) May we leave a message? □ Yes □ No

E-mail: ______________________________________ May we email you? □ Yes □ No

Date of your last physical exam: ____

Have you been diagnosed with a mental health disorder by a mental health professional?
□ No
□ Yes, the diagnosis was: ____

by: ____
(Name) (Title) (Year diagnosed)

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous name(s) of therapist/practitioner:

____
(Name) (Title) (Year and length of treatment)

Have you ever been prescribed or are you currently taking any psychiatric medication?
□ No
□ Yes, the following prescriptions:
____

NEUROFEEDBACK QUESTIONNAIRE

Please describe why you are seeking neurofeedback:

____

____

List of concerns (list in order of importance):	How long have you been experiencing these concerns?