Symptom Checklist

Name:_____ Today's Date:_____
Email to receive weekly reminders:_____
Date of Birth:_____

1. Please check all Applicable Symptoms/Ailments that you have been experiencing
2. When finished checking the applicable items, please circle the top 4-5 that you would especially like to focus on while working with us. (Note: Circle 4 total, irrelevant of the categories)

Sleep

Difficulty falling asleep		Nightmares or vivid dreams	
Difficulty maintaining sleep		Periodic leg movements	
Difficulty waking		Restless leg(uncontrollable urge to move)	
Dysregulated sleep cycle (inconsistent bedtime/wake routine)		Sleep walking	
Bruxism (teeth grinding)		Talking during sleep	
Narcolespy (sudden attacks of falling sleep)		Sleep apnea(breathing stops and starts)	
Night sweats		Snoring	
Nocturnal Enuresis(bedwetting)			

Attention and Learning

Difficulty completing tasks		Difficulty following direction	
Difficulty making decisions		Difficulty organizing personal time/space	
Difficulty remembering names		Difficulty shifting attention	
Difficulty shifting tasks		Difficulty thinking clearly	
Difficulty understanding conversations		Distractibility	
Lack of alertness		Lacking common sense	
Messy handwriting		Not listening	
Poor concentration		Poor drawing ability	
Poor math		Poor short-term memory	
Poor sustained attention		Poor long-term memory	
Poor vocabulary		Poor word finding	
Learning Disability		Slow thinking	
Unmotivated		Difficulty recognizing faces	
Confusion		Poor verbal expression	
Reading Problems		Developmental delay	
Dementia			

Sensory

Auditory(sound) hypersensitivity		Chemical sensitivity	
Motion sickness		Poor body awareness	
Somatosensory (sensory -such as pressure, pain, warmth) deficits		Tactile(touch) hypersensitivity	
Tinnitus (ringing or buzzing in the ear)		Vertigo (sensation of spinning/dizziness)	
Visual deficits		Visual hypersensitivity (sensitive to lights/flashing/movement in visual field)	
Driving vehicle difficulties		Autism	
Sensory processing disorder		Anosmia (loss of smell)	

Behavioral

Addictive behaviors (video games, drugs, alcohol, sex, gambling etc.)		Aggressive behavior	
Anorexia (eating disorder)		Autistic stimming (repetitive movements/sounds)	
Binging(excessive eating) and purging(vomit/laxatives)		Class clown	
Compulsive behaviors		Compulsive eating	
Crying		Excessive talking	
Hyperactivity		Impulsivity	
Inflexibility		Lack of appetite awareness	
Lack of sense of humor		Lack of social interest	
Manipulative behavior		Motor or vocal tics	
Nail biting		Oppositional or defiant behavior	
Poor eye contact		Poor grooming	
Poor social or emotional reciprocity		Poor speech articulation	
Rages		Self-injurious behavior	
Stuttering		Slow motor	
Slow speech		ADD (Attention Deficit Disorder)	
Criminal Behavior		ADHD (Attention Deficit Hyperactivity Disorder)	

Emotional

Agitation		Anger	
Anxiety		Depression	
Difficult to soothe		Dissociative episodes-detachment from surroundings/self	
Easily embarrassed		Emotional reactivity	
Fears		Feelings of unreality	
Flashbacks of trauma		Impatience	

Irritability		Lack of emotional awareness	
Lack of pleasure		Lack of social awareness	
Low self-esteem		Mania (periods of great excitement, euphoria, delusions, and overactivity)	
Mood swings		Obsessive negative thoughts	
Obsessive Rumination /worries		Panic attacks	
Paranoia		Suicidal thoughts	
Phobia (fears)		Suicide Attempts	
OCD(Obsessive Compulsive Disorder)		Delusions, Hallucinations or Thought Disorder	
Mental Fogginess		Bipolar Disorder	

Physical

Allergies		Muscle weakness	
Chronic constipation		Asthma	
Difficulty walking or moving		Clumsiness	
Effort fatigue (fatigue from task that requires mental and/or physical energy)		Difficulty working	
General Fatigue		Encopresis (involuntary defecation)	
High blood pressure		Heart Palpitations	
Immune deficiency		Hot flashes	
Low muscle tone		Muscle tension	
Muscle twitches		PMS symptoms	
Nausea		Poor fine motor coordination	
Thyroid Problems		Reflux	
Poor balance		Seizures	
Poor gross motor coordination		Spasticity (muscles are continuously contracted)	
Rigidity		Sugar Cravings and reactivity	
Skin rashes/eczema		Tachycardia (abnormally rapid heart rate)	
Stress incontinence		Urge incontinence (urge to urinate)	
Sweating		Irritable bowels	
Tremor		Skull/Head Surgeries	
Concussion		Deformities	
Strokes		Heart Attacks	
Menopausal		Incontinence (involuntary leakage of urine or feces)	
Metabolic Disorders (e.g. diabetes)		IBS(Irritable Bowel Syndrome) or Crohn's Disease	
Hypoglycemia (low blood sugar)		Lyme Disease	

Pain

Abdominal Pain		Chronic aching pain	
Chronic Nerve Pain		Fibromyalgia pain	
Jaw pain		Joint pain	
Migraine headaches		Muscle Pain	
Sinus headaches		Sciatica (lower back/leg pain)	
Tension headaches		Stomach Aches	
Trigeminal neuralgia (chronic pain affecting the face)		Chronic Ear Infections/Ear Tubes	

Previous Diagnoses & Tx:

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Please answer the following questions:

Usual Hours of Sleep per Night: _____

Did your mother smoke cigarettes during her pregnancy with you? Yes / No / Don't Know

Did your mother use alcohol or drugs during pregnancy? Yes / No / Don't Know

Did you experience any extremely high fevers or illness during childhood especially during the first two years of life?_____

_____

Did you have a complicated birth? (premature,forceps, fetal distress, anoxia, prenatal drug exposure, complicated/prolonged labor)_____

_____

Were you born by caesarian section(C-section)? Yes / No / Don't Know

Have you had exposure to toxic agents (heavy metals, insecticides, carbon monoxide, solvents, drug overdoses, chemotherapy or radiation, etc.)_____

_____

Head Injury History:

1. Blows to the Head or *Head Injuries* from sports or accident-related injuries, with or without loss of consciousness, **diagnosed** by a professional as concussion. Please describe:_____

_____

_____

_____

2. Possible concussion or subconcussive events: Blows to the head from sports, falls with hitting of head, car accidents with whiplash resulting in headache, dizziness, nausea, exhaustion, or seeing stars. Please describe:_____

_____

_____

_____

3. Total Number of Head Injuries: _____

Have you had any prior experience with neurofeedback/biofeedback?_____

_____

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