



TECHNOLOGIES

MCN: MICRO CURRENT NEUROFEEDBACK

NEUROFEEDBACK ASSESSMENT

Date of assessment: ___/___/___

Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: ___/___/___ Age: ___ Sex: ___

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) ____-____ Email: _____

Legal Guardian: _____

(If patient is a minor)

School/Grade: _____

(If applicable)

Occupation: _____

Emergency Contact: _____

Phone: (____) ____-____

PERSONAL HISTORY:

1. PAST MEDICAL HISTORY (Please list any illness/diagnosis, physical injury, head injury – brain injury/concussion/whiplash/falls, surgeries):

2. MEDICATIONS (please include supplements):

NAME	DOSE	REASON FOR TAKING
1)		
2)		
3)		
4)		
5)		

3. ALLERGIES (please list medication and food allergies):

MEDICATION	FOOD	REACTION
1)		
2)		
3)		
4)		
5)		
6)		

4. FAMILY HISTORY (G = grandparents, P = parents, S = self):

Cancer	G	P	S	Thyroid	G	P	S	Mental illness	G	P	S
Heart disease	G	P	S	Diabetes	G	P	S				
Lung disease	G	P	S	Autoimmune	G	P	S				

Other (please describe):

5. SOCIAL HISTORY (Y = yes, N = no, P = past):

Alcohol	Y	N	P	Antacids	Y	N	P	Addiction	Y	N	P
Smoking	Y	N	P	Laxatives	Y	N	P				
Steroids	Y	N	P	Pain meds	Y	N	P				

Addiction treatment(s): _____

6. EMOTIONAL HISTORY (Y = yes, N = No, P = past):

Anxiety	Y	N	P	Anger	Y	N	P	Panic	Y	N	P
Depression	Y	N	P	Irritability	Y	N	P	Abuse history	Y	N	P
Insomnia	Y	N	P	High strung	Y	N	P	Food addiction	Y	N	P
Suicidal	Y	N	P	Fear	Y	N	P	Eating disorder	Y	N	P
PTSD	Y	N	P	Guilt	Y	N	P	OCD	Y	N	P

Additional comments:

REVIEW OF SYMPTOMS:

1. **PAIN:**

A. Headaches:

How often? _____

Location? _____

Severity? _____

History of Migraine headache? Yes No

Triggers: _____

B. Body/joint/limb pain? Please describe:

Fibromyalgia? Yes No

Photophobia (sensitivity to light)? Yes No

Hyperacusis (sensitivity to/pain from sound)? Yes No

What makes your pain better? _____

What makes your pain worse? _____

2. **SLEEP:**

Do you have difficulty falling asleep? Yes No

Do you have difficulty staying asleep? Yes No

How many hours do you sleep per night? _____

How many hours' sleep do you need? _____

Do you wake feeling rested? Yes No

Nightmares? Yes No

Additional comments:

3. FOCUS/CONCENTRATION/MEMORY:

ADD/ADHD? Yes No Medication/Treatment: _____
Poor concentration? Yes No
Impulsivity? Yes No
Difficulty making decisions? Yes No
Easily distracted? Yes No
Racing thoughts? Yes No
Disorganized? Yes No
Overwhelmed by stimuli? Yes No

4. NEUROLOGICAL:

Seizures? Yes No Type: _____
Stroke? Yes No Location: _____
Tremors? Yes No
Traumatic Brain Injury? Yes No
Vertigo? Yes No
Tinnitus (ringing in the ears)? Yes No
Hearing loss? Yes No
Poor balance? Yes No

5. IMMUNE/ENDOCRINE/AUTONOMIC NERVOUS SYSTEM:

Immune deficiency? Yes No
Adrenal insufficiency? Yes No
Chronic Fatigue Syndrome? Yes No
Multiple Chemical Sensitivities? Yes No
Asthma? Yes No
Irregular Menstrual Periods? Yes No
Premenstrual Syndrome (PMS)? Yes No
Menopause? Yes No
Constipation? Yes No

Additional comments:

PRACTITIONER NOTES:
