KAIZEN | HEALTH

NEUROFEEDBACK INTAKE QUESTIONNAIRE

Please note, this questionnaire is not a screening device but is used to prepare for your first neurofeedback session. Please take your time to answer all the questions as honestly as possible. Please consider the most common or usual way you are in giving your response. I am interested in your experience of being alive in the world, which includes your physiological as well as emotional reactions to events in your life. The questions are divided in to categories of experience.

SLEEP SYMPTOMS

1. What time do you normally go to bed? Why do you go to bed when you do? Do you ever put off going to bed?

2. How long do you typically sleep? Is this a consistent pattern?

3. How long does it take you to fall asleep? If it is longer than 10 minutes, what was going on in your mind?

4. If it ever takes you longer than 10 minutes, how often does this occur? Once a week, once a month, once a year?

5. How often do you wake in the night? Do you know why you woke? If you wake, how long does it take you to fall back asleep? If it takes you a while to fall back to sleep, what's going on when you aren't falling asleep? Are you going over things in your mind? Or are you unable to fall asleep and then you start thinking about things?

6. Do you sleep soundly? Restlessly? Other?

7. Is it difficult to get up? Do you use an alarm? Are you tired? Draggy? Do you need coffee? How long does it take before you really get going?

8. What time do you wake up?

9. Do you feel well when you get up? If not, why?

10. If you could sleep as long as you want, would you wake rested?

11. Do you snore or have sleep apnea?

12. Do you have night sweats? Either hypoglycemic or menopausal?

13. Do you wet the bed?

14. Do you have or have ever had narcolepsy?

ATTENTION SYMPTOMS

1. Are you often inattentive or find yourself daydreaming?

2. Do you have poor sustained attention, even if it is something enjoyable? If you are watching a movie at home, do you find other things to do simultaneously?

3. Does reading a book put you to sleep, even during the day? Do you remember what you read?

4. How motivated are you?

5. Do you have a “busy brain”? Do you have many competing thoughts?

6. Are you impulsive? How do you go about making a decision?

7. Do you fidget? Do you have constant hand or leg movement?

8. Are you easily distracted?

9. Do you often feel bored?

10. Are you hyperactive? Do you often feel like you can't contain yourself?

11. Do you experience hyperactivity after eating sugar?

12. Do you experience hyperactivity with fatigue or sedatives?

EMOTIONAL AND BEHAVIORAL SYMPTOMS

1. Do you have excessive worry? Do you have performance or error anxiety?

2. Are you a perfectionist? Do you feel the need to get everything right?

3. Are you easily embarrassed?

4. Are you irritable? Do you find yourself easily provoked?

5. Are you excessively emotional? Do you cry easily?

6. Are you depressed? Do you find yourself sad, hopeless, or helpless?

7. How is your self-esteem? Do you generally feel good about yourself?

8. Are you passive or shy?

9. Do you often experience anxiety? Do you feel fearful and have physiological arousal?

10. Are you angry a lot? How long does it take to let go of anger? Do you hold grudges? Have you ever felt full of rage?

11. Do you get agitated? How long does it take to calm down?

12. Are you aggressive? Do you initiate conflict? Can you be violent?

13. Are you impatient?

14. Do you experience manic-depressive cycles?

15. Do you, or have you ever, experienced panic attacks?

16. Do you have or have had an eating disorder? Anorexia, bulimia, or binge eating?

17. Do you have any motor or vocal tics? Do you hum?

18. Do you obsess or ruminate about things?

19. Have you ever considered suicide?

20. Do you have dissociative symptoms?

21. Do you suffer from Post Traumatic Stress Disorder?

22. How do you relax? How much time do you spend watching TV or playing on the computer?

RESPONSE TO COFFEE, ALCOHOL,
STIMULANTS, DRUGS AND MEDICATIONS

1. How often do you drink coffee, tea, coke or other caffeine-loaded drinks?

a) Do you know how caffeine makes you feel?

b) What times do you drink them? Do you ever drink them at other times?

c) Do you "need" caffeine?

d) What would happen if you didn't drink them? Could you just stop?

e) How do you feel if you've had too much, and how much is too much?

2. How do you feel when you've had one glass of wine, beer, or a drink?

a) How about when you've had two drinks?

b) Does it make you feel good?

c) How do you feel if you've had too much, and how much is too much?

d) How many drinks might you have in a week? A month? Do you ever go through periods where you stop? Why?

3. Do you or have you ever smoked? How did/does it make you feel? What happens when you stop?

a) If you smoked, how much did you smoke when you did?

4. Are you sensitive to medication? That is, do you often have to take less than the doctor prescribes because you might over-react to the standard dose?

5. I am looking for how your brain responds to what it is exposed to from a physiological perspective. I don't care what you may have done, it just gives me clues what type of training might be helpful. Many people at various times in their lives have used recreational or popular drugs socially. These have different types of responses on the brain. Did you ever try any drugs, and can you tell me how you responded to them?

PAIN SYMPTOMS

1. Tension headaches?

2. Migraine?

3. Chronic aching pain?

4. Chronic, burning pain or sharp, throbbing pain?

5. Sciatica pain?

6. Do you suffer from fibromyalgia?

7. Do you have emotional reactivity to pain

NEUROLOGICAL AND MOTOR SYMPTOMS

1. Have you had a stroke? Which side? Any paralysis? Which side?

2. Do you have poor balance or poor coordination?

3. Do you have seizures?

4. Do you have tinnitus?

5. Is there any known traumatic brain injury? Have you ever been hit hard in the head? Fell and hit your head? Bumped your head very hard? Have you ever been knocked unconscious?

a) Was there any change you noticed in any way after that? Cognitive? Emotional? Behavioral? Other?

6. Have you ever gone under major anesthesia? How did you come out of this state?

7. Have you ever had a large exposure to any major chemicals/pesticides or other things that impacted you cognitively or neurologically?

COGNITIVE TYPE SYMPTOMS

1. Do you have dyslexia, poor reading comprehension, poor arithmetic calculation or poor sequential processing?

2. Do you have poor visuospatial skills (not good at Geometry typically)?

3. Is it hard for you to write neatly? Is it hard to draw? Does holding a pen feel awkward?

4. Do you have a poor sense of direction?

DEVELOPMENTAL HISTORY

1. Was there any perinatal stress or injury?

2. Was there any prenatal drug exposure?

3. Were you premature? If so, how early? And what were the circumstances?

4. Were there any early problems with eating, sleeping, walking or talking?

5. Were there any serious illnesses or injuries when you were young?

MEDICATIONS

1. Please list any medications and dosages you are currently taking.

2. Have you had a good or bad reaction to antidepressants?

3. Have you had a good or bad reaction to stimulants?

4. Have you had a good or bad reaction to sedating medications?