Metrowest NEUROFEEDBACK
Brain training for adults & kids

CHILD EVALUATION

Name:

Date:

DOB/Age:

M or F

School:

Grade:

Handedness: ☐ L ☐ R Mixed ☐

GOALS: *Please list three goals for neurofeedback training*

1.

2.

3.

EMOTIONS:

Anxiety

Depression

Mood swings

Fears

Frustration

Anger

Tantrums

Obsessive worries

SELF-CONCEPT:

How child feels about self

PEERS AND PLAY:

Friends

SCHOOL:

Teacher complaints

Problems with other students

Homework

LANGUAGE AND THINKING:

Verbal expression

Reading

Spelling

Writing

Math

Art

Sense of direction

Memory

CONCENTRATION AND ORGANIZATION:

Attention

Distractibility

Impulsivity

Ability to organize time and space

ACTIVITY LEVEL AND MOTOR ACTIVITY:

Over-active or under-active

Coordination

Accident prone

Sense of self in space

Motor tics

Vocal tics

BEHAVIOR:

Uncooperative

Inflexible

Unpredictable

Manipulative

Insensitive to others

Oppositional

Defiant

Aggressive

VALUES:

Lying

Cheating

Stealing

Not know right from wrong

No guilt feelings

HABITS:

Sleep

Bedwetting

Nightmares or night terrors

Soiling

Teeth grinding

Eating habits

Awareness of appetite

Food sensitivities

Food cravings

Sugar craving or reaction

Compulsions

HEALTH HISTORY:

Frequent illness

Headaches

Stomachaches

Chronic constipation

Allergies

Asthma

Pain

Fainting

Seizures

Hearing problems

Vision problems

PERSONAL HISTORY

PERINATAL:
Prenatal stress or injury
Prenatal drug exposure
Difficult labor
Difficult birth
Premature or late birth
Medical problems after birth
Adopted at age _____

GROWTH AND DEVELOPMENT:
Colic
Sleep problems
Eating problems
Activity level
Attachment
Emotional development
Motor development
Language development
Chronic ear infections
Allergies
Asthma

PHYSICAL TRAUMAS:
Head injury
Accidents
High fever
Serious illness
CNS infection
Drug overdose
Poisoning
Anoxia
Stroke

PSYCHOLOGICAL TRAUMAS AND STRESSES:

Abuse or neglect
Family stress
School or job stress
Death in family
Illness

TREATMENT HISTORY

MEDICATIONS:

Medication	For Condition	Dose	Dates

MEDICAL TREATMENT:

Procedure	For Condition	Description	Dates

PSYCHOLOGICAL THERAPY:

Therapy	For Condition	Therapist	Dates

OTHER THERAPY:

Therapy	For Condition	Therapist	Dates

FAMILY HISTORY

Symptom	**Yes**	**No**	**Relationship**
Asthma	☐	☐	
Autoimmune Disorders: Type 1 Diabetes, Rheumatoid Arthritis Lupus, MS, Scleroderma, etc.	☐	☐	
Thyroid disorder	☐	☐	
Migraine	☐	☐	
Sleep Problems	☐	☐	
Depression	☐	☐	
Manic-depression	☐	☐	
Anxiety	☐	☐	
Phobias	☐	☐	
Panic Attacks	☐	☐	
Motor or Vocal Tics	☐	☐	
Seizures	☐	☐	
Eating Disorders or Obesity	☐	☐	
Addictions	☐	☐	
Obsessive Compulsive Symptoms	☐	☐	
Speech Problems	☐	☐	
Attention Problems	☐	☐	

Hyperactivity	☐	☐	
Learning Problems	☐	☐	
Conduct Problems or Criminal Behavior	☐	☐	
Autism spectrum	☐	☐	
Schizophrenia	☐	☐	