Zen Brainz
NEUROFEEDBACK

INTAKE / 24 HR POST TREATMENT FORM

(Please circle the appropriate form whether INTAKE or 24 HR POST TREATMENT)

NAME:_____

DATE: _____SESSION #_____

(PLEASE ANSWER OF THE FOLLOWING QUESTIONS USING A 1- 10 SCALE…1 being the best & 10 the most troublesome)

1. Do you get headaches? If yes, how often & what part of your head hurts? Do you have a headache now?

2. How would you characterize your sleep?

3. How is your digestion?

4. How is your energy level?

5. How reactive are you, reference being triggered by others or by circumstances?

6. How is your recoverability/resiliency to being triggered?

7. How is you sustainability/ability to sustain positive changes?

8. How is your productivity?

9. Do you feel pain from light? (Photophobia). Y N

10. Do you feel pain from sound? (Hyperacusis). Y N

11. Please list any other symptoms you may be experiencing? (Examples: Depression, Anger, Restlessness, Loss of Appetite, suicidal thoughts)

If you have experienced traumatic brain injury or have headaches, please place an X on the image below representing the involved area.

PATIENT TREATMENT LOG:

TREATMENT NUMBER_____/PROTOCOL_____/SITE PAIRS_____

NUMBER OF EXPOSURES_____/NUMBER OF CYCLES_____/IR USE_____