

CHILD EVALUATION

Name: _____ DOB: _____

Date: _____ Age: _____ School: _____ Grade: _____

Handedness: Left Right 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 organizational 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 Teeth grinding

Eating habits _____

Awareness of appetite _____

Food sensitivities _____

Food cravings _____

Sugar craving or reaction _____

Compulsions _____

HOME BEHAVIOR:

Problems with parents: _____

Problems with siblings: _____

PERINATAL:

Adopted at age: _____ Prenatal stress or injury _____

Prenatal drug exposure _____

Difficult labor Difficult birth Premature or late birth

Medical problems after birth _____

GROWTH AND DEVELOPMENT:

Colic Chronic ear infections Asthma

Sleep problems _____

Eating problems _____

Activity level _____

Attachment _____

Emotional development _____

Motor development _____

Language development _____

Allergies _____

HEALTH HISTORY:

Frequent illness Headaches Stomach aches Chronic constipation

Allergies _____

Asthma Pain Fainting Seizures Hearing problems Vision problems

PERSONAL HISTORY**PERINATAL:**

Adopted at age: _____ Prenatal stress or injury _____

Prenatal drug exposure _____

Difficult labor Difficult birth Premature or late birth

Medical problems after birth _____

GROWTH AND DEVELOPMENT:

Colic Chronic ear infections Asthma

Sleep problems _____

Eating problems _____

Activity level _____

Attachment _____

Emotional development _____

Motor development _____

Language development _____

Allergies _____

PHYSICAL TRAUMAS:

- Head injury _____
- Accidents _____
- Serious illness _____
- High fever CNS infection Poisoning Anoxia Stroke
- Drug overdose _____

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	Reaction / Side Effects

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, Sclerodema, etc.			
Thyroid disorder			
Migraine			
Sleep Problems			
Depression			
Manic-depression			
Anxiety			
Phobias			
Panic Attacks			
Motor or Vocal Tics			
Seizures			
Eating Disorders or Obesity			
Addictions			
Hyperactivity			
Learning Problems			
Conduct Problems or Criminal Behavior			
Autism spectrum			
Schizophrenia			