**Hadassah Brain Center**

BIOFEEDBACK INTAKE & CONSENT FORM

Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (Cellular)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Birth (include city, please)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications and dosages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in the care of a primary physician? \_Yes No

How did you hear about us? Please be specific. If through referral, who may we thank? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a Biofeedback Session before? \_Yes \_No If yes, when was your last session? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please specify the number of previous sessions. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sensitive to touch? Yes No

Do you have a particular area of concern? \_Yes\_ No\_ Unsure

If yes, please tell us the reason for your session today (be as specific as possible): Specific Issues:

Physical:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emotional:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spiritual:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under stress? On a scale of 1-2-3-4-5-6-7-8-9-10, where 1 is minimum stress and 10 feeling you are under extreme stress, please circle the number you most identify with. Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a pacemaker? \_\_\_\_YES\_\_\_\_NO

Have you been diagnosed with Epilepsy or have seizures? \_\_\_YES\_\_\_NO

Are you Pregnant? \_\_\_YES\_\_\_N/A Is your child under the age of three years of age? \_\_\_YES\_\_\_N0

Are you taking prescription drugs? YES\_\_\_N0\_\_\_ If yes, please specify as best you can. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take multi-vitamins on a regular basis? YES\_\_\_NO\_\_\_

Do you know if you absorb nutrients well? YES\_\_\_NO\_\_\_

Do you suffer from gas, bloating or indigestion? \_\_YES\_NO\_ Unsure

Do you have any known food allergies or intolerances? \_\_\_YES\_\_\_NO If yes, please specify below. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from a gastrointestinal disorder such as inflammatory bowel disorder or leaky gut syndrome? \_\_\_YES\_\_\_N0

Do you eat a diet that is high in sugars and processed food? \_\_YES\_\_\_N0

Are you prone to infections? \_YES\_\_\_N0

Do you use antacids on a regular basis? \_YES\_\_\_N0

Do you smoke? \_YES\_\_\_N0

Do you drink? YES\_\_\_NO\_\_\_ If yes, how many times per week do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you exposed to heavy metals?\_\_\_YES\_\_\_N0

How many glasses of water do you drink every single day?

Please circle the number that reflects best your behavior. 1 - 2- 3- 4- 5- 6- 7- 8 more than 8 Have you had any injuries in the past? YES\_\_\_NO\_\_\_

if yes, please explain what area in the body was affected the most.

Have you had any of the following symptoms RECENTLY (over the past month)?

Headaches, Chest Pain, Weight Loss, Eye Pain, Anxiety, Weight Gain, Blurred Vision, Depression, Frequent Fevers, Double Vision, Skin Rash, Sinus Congestion, Hearing Loss, Tremor, Frequent Infections, Ringing in the Ears, Vomiting, Arm Pain, Dizziness/Lightheaded, Nausea, Arm Weakness, Difficulty Swallowing, Stomach Pain, Arm Numbness, Difficulty Speaking, Stool Incontinence, Arm Tingling, Facial Weakness Diarrhea Leg Pain Facial Numbness Constipation Leg Weakness Back Pain Blood in Stool Leg Numbness, Neck Pain, Trouble Urinating, Leg Tingling, Racing Heart Rate, Joint Pain, Frequent Cough, Painful Urination, Shortness of Breath, Impotence,

Have you had any neurological studies performed (MRI, CT, EEG, EMG)? If so, when?

Please provide details about any of the symptoms above that are currently bothering you: Are there any other symptoms that are bothering you that were not listed above?

Biofeedback and Neurofeedback are used for conditions that include ADD/ADHD, depression, anxiety, headaches, addiction disorders, psychological, and neurological disorders. Neurofeedback is one part of several therapies or changes that must occur in the patient’s life for the benefits of Neurofeedback to be lasting.

How does Biofeedback and Neurofeedback feedback work?

1. Brainwave activity and other measurements from the body like muscle tensing or skin temperature are measured

2. The measurements are fed back to the patients in a form they can understand, like sound, light, pictures, or videos that can change in brightness or loudness, or activity, as the brainwave activity changes.

3. The patient learns to adjust their brainwaves or muscle tensing or hand temperature as they change what they see or hear.

How is Biofeedback or Neurofeedback done?

Sensors are attached around the waist, to the fingers, the jaw, forehead or shoulders, the earlobes, and the head to gather information. Nothing is done to the patient other than what would be done when an EKG (electrocardiogram) is recorded. The sensors simply measure changes in systems monitored. The information is seen on a computer screen and heard through speakers or headphones. The client can see and hear changes in their physiological activity and, by practicing self-regulation techniques such as relaxation and breathing, the client can learn to correct imbalances in the systems being monitored. This process results in improvement in the client’s presenting condition(s) as these functional problems are corrected. Hadassah Brain Center makes no claim or guarantee that biofeedback training will be effective for all specific concerns. All client records and transactions are confidential unless release of these records is authorized in writing by the client, or otherwise required by law. Patients will have access to their records. I have read and understood this document; I have had the opportunity to ask questions and have had those questions answered to my satisfaction.

PLEASE READ CAREFULLY AND SIGN BELOW

 I understand that the intended purpose of biofeedback training is for brain training, optimize muscle relaxation, brain wave operant conditioning, so I may learn to: 1) reduce my stress, 2) manage my pain, and/or 3) improve the equality of my health and my life. I understand biofeedback training is considered safe and non-invasive. I further understand that biofeedback is not a substitute for standard medical advice from my physician. I further understand it is my responsibility to ask my medical doctor for permission to undergo biofeedback training if I wear a peacemaker or have any medical conditions. I understand it is my responsibility to monitor the effects of biofeedback training and to continue the training for as long as it is beneficial to me. I further understand that research suggests that while most people gain considerable benefits from biofeedback training, I understand there is no guarantee that it will. I understand Hadassah Brain Center does not except insurance and is not contracted with insurance networks for billing.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_