

QEEG/Brain Map Instructions:

1. Get a good night's sleep.
2. Do not take Antihistamines at least 8 hrs prior to test.
Do not take ADHD medication prior to test.
(Please call if you have any questions.)
3. Clean hair, no gels and or sprays.
4. No make up on the forehead.
5. Eat a protein based breakfast like eggs & meat.
6. Bring a cap or scarf as your hair may be damp from the test.
7. **DO NOT** wear contact lenses; they will need to come out for the test.
8. Cell phones must be turned off during the test.
9. No Recreational drugs or alcohol 3 days prior to the test.
10. Most supplements are ok, except amino acids and protein powders.
11. No medical marijuana within 3 days. Will show depression on map.

The Brain map or QEEG, is an essential part of the process of establishing **your** Neurofeedback program. It also gives us vital information about how efficiently **your** brain is processing and what areas of your brain may need remedial training. This non-invasive procedure employs electroencephalographic (EEG) equipment to evaluate brain wave patterns to determine where to make necessary changes to enhance brain performance. The four major frequencies of the brain that we measure are delta, theta, alpha, and beta. By comparing **your** EEG brain wave patterns to baseline data in our computers, we can determine how well each area or **your** brain is functioning. This valuable information will help determine the protocol to employ to achieve the best results with **your neurofeedback program**.

- Hair will be a little messy after the testing. People usually plan to go home after the testing to wash their hair.

NeuroIntegration Intake Form

PERSONAL INFORMATION

Name _____
 Address _____
 City _____ State _____ Zip _____
 Email address _____

Date of birth ____/____/____
 Age _____ years
 Gender M _____ F _____

Home Phone _____
 Work Phone _____
 Occupation _____

Cell Phone _____
 Fax _____

Tell us more about your needs and desires regarding brain health.

How can we help? What are you hoping to address or achieve through our NeuroIntegration Program?

HEALTH INFORMATION

1. OVERALL HEALTH

On a scale of 1-10, how would you rate your current health? 1 2 3 4 5 6 7 8 9 10
 (1 being the worst, 5 being average, 10 being the best)

2. SLEEP

Rate the quality of sleep you usually get in the past month. 1 2 3 4 5 6 7 8 9 10
 At what time do you go to bed? _____ am/pm
 At what time do you rise in the morning? _____ am/pm

Are you able to sleep through the night? YES NO
 If NO, please describe:

Are you able to fall asleep easily most nights? YES NO
 If NO, please describe:

Do you wake refreshed? YES NO
 If YES, please describe any exceptions:

3. HEAD or NECK INJURY

Have you ever injured your head or neck? YES NO
 Ever had a concussion? YES NO
 If yes, have you suffered more than one concussion? YES NO
 Have you ever been in an auto, motorcycle or bicycle accident? YES NO
 Have you ever had a traumatic brain injury? YES NO
 Are you currently receiving care for this/these injuries? YES NO

Please describe your head or neck injuries using the reverse side of this page, thinking back over the years. Please consider the childhood and teen years, as well as adulthood, including home life, sports, accidents, slips/falls, etc.

4. CHRONIC HEALTH PROBLEMS?

Please list any chronic medical problems or brain health issues you have on the back side of this form.

5. HORMONES

Are you concerned that hormonal imbalances that may be contributing to your condition? YES NO

6. MOODS & EMOTIONS

How would you describe your general emotional state? (A brief sentence or short phrase of 3-4 words is fine.)

7. MEDICATIONS, SUPPLEMENTS & VITAMINS

If you haven't previously listed these on our intake form, please provide a list here including name, dose, frequency and for what symptom you are taking each. Feel free to use the other side.

Medications

Nutrition Supplements/Vitamins

ANY KNOWN MEDICATION ALLERGIES?

YES

NO

Please list any medication allergies you may have:

8. SUBSTANCES

Do you currently use psychoactive drugs, medications or alcohol to pick yourself up or calm yourself down?

YES

NO

Have you ever used psychoactive drugs, medications or alcohol in the past to pick yourself up or calm yourself?

YES

NO

Are you currently a smoker?

YES

NO

Do you consider your current use of tobacco, alcohol or street drugs a problem?

YES

NO

If yes on any of these substances, circle those currently taking.

Do you feel depressed or anxious at the present time?

Depressed
Neither

Anxious

Have you suffered from depression or anxiety in the past?
Circle condition if yes.

YES

NO

9. ATTENTION & LEARNING

Any history of learning difficulties?

YES

NO

Any history of memory problems?

YES

NO

Any history of ADD/ADHD?

YES

NO

In childhood? Adulthood? (please circle)

10. OTHER CONDITIONS

Any history of other psychiatric conditions in yourself, such as schizophrenia, bi-polar disorder, psychosis?

YES

NO

Any history of other psychiatric conditions in family members, such as Schizophrenia, bi-polar, psychosis?

YES

NO

11. COUNSELING & PSYCHOTHERAPY

Are you currently working with a psychiatrist, therapist, counselor or clergy in matters regarding your mental health?

YES

NO

If yes, please list name/names _____

12. SEIZURES or LIGHT SENSITIVITY?

Are you, or have you ever been, sensitive to lights or strobe lights, had or been diagnosed with migraines or epileptic seizures?

YES

NO

13. Is there anything that you would like to add?

Parent or Guardian of Minor, please complete this section

Parent/Guardian Name _____

Address _____ City _____ State ____ Zip _____

Do you live with the patient? Y N Phone _____

Informed Consent for NeuroIntegration Therapy

This practice offers NeuroIntegration Therapy, also known as EEG (brain wave) biofeedback (neurofeedback) training, to clients requesting such services. The training is offered to children and adults, either self referred or identified by parents, physicians, teachers or other referral sources as having conditions shown to be responsive to this training. These conditions are generally thought to be those that appear to be associated with irregular brain activity where there is also clinical and research evidence to suggest neurofeedback training as a viable treatment approach.

Our staff has education, training and experience in neurofeedback and in EEG technology in addition to related professional disciplines such as psychology and naturopathic medicine. We recommend the training on the basis of our observations of improvement in clients with similar conditions. Scientific investigation is ongoing to determine the mechanism by which these improvements are achieved and therefore EEG neurofeedback is considered by many to be an experimental treatment at this time. We use standard methods to determine the proper training program and to measure progress during and after training. Neurofeedback is, however considered an experimental approach and therefore we need client or parental informed consent for this training.

We do not claim that you or your child will improve from the training. However, test results indicate that more than 80% of clients improve on at least one test scale and more than half improve on three out of four scales. A few clients who seem to get better at first may find that the improvement does not last after the training ends. Such clients may benefit from regular follow-up sessions. Some individuals may not experience any effects at all from the training. Our staff is always happy to discuss client progress. Other methods may also be effective for you or your child. We will be happy to provide information about such services at your request. Individual and/or family counseling may help you and/or your child integrate the gains from neurofeedback into everyday family, social, school and work environments.

Neurofeedback training has been the subject of more than 30 years of research and clinical study. The training appears to be harmless as far as is known at present and no injuries have been reported, or in a review of research literature. Neurofeedback does not do anything to your child. It is not a treatment; it is a training process. The instruments are merely measuring devices similar to a thermometer. Sensors are placed on the surface of the head and your child is given information about what is being measured. Nevertheless, beyond this, We do not make any representation concerning the safety or effectiveness of the training. Any questions should be addressed to one's personal physician. Clients should continue ongoing therapies until otherwise advised by a physician.

When you sign this form, you are indicating that you understand the information that it contains.

When you agree to participate in this program, you or your child are not obligated to complete the training if for any reason you believe it is not in your or your child's best interest. This means you may discontinue participation at any time. Training and test results will be available to clients and/or parents.

If you, or anyone else who will use this machine, are subject to any form of seizures, epilepsy or visual photosensitivity please notify us prior to starting Neurofeedback training.

Yes, I understand and agree to the terms of this document. **Yes, you may administer standard tests**

Name of Client: _____ **DOB:** _____ **Phone #:** _____

Client Signature: _____ **Date:** _____

Parent/Guardian Name (if client is a minor): _____ **Phone #:** _____

Parent/Guardian Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

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