VHMEC
VISIONARY HEALTH MEDICAL EDUCATIONAL CLINIC
"HEALING WITH HEART"

Visionary Health Medical Educational Clinic (VHMEC)
5359 Dundas St West Unit 108, Toronto, ON M9B1B1 647-478-9029 FAX: 647-557-3323
vhmec108@gmail.com info@vhmec.com www.vhmec.com

Neurofeedback/ Biofeedback Intake Form

1. Personal Information

Name ______________________ **Date** ______________________
Age ________ **DOB** ____________ **Gender** ☐M ☐F ☐M-F ☐F-M ☐Other
Address ______________________ **Home phone** ______________________
______________________ **Cell phone** ______________________
Referral Source ______________________
Race/Ethnicity ______________________ **Primary Language** ______________________
Email address ______________________

Emergency Contact
1. ______________________ **Phone:** ____________ **Relation:** ______________________
2.Do you have a primary medical/psychiatrist provider? ☐Yes ☐No
If yes, who? ______________________ **Phone number:** ______________________
3. Do you have an emotional support care member? ☐Yes ☐No
If yes, who? ______________________ **Phone number:** ______________________
____

2. Presenting Concerns: Please provide a brief description of what brings you in for the neurotherapy session?

1. ____
2. ____
3. ____

How, if at all, do the above issues affect the following areas of your work/school/relationship or responsibilities:
____
____

3. Goals for Neurofeedback: Briefly describe goals you have for your neurofeedback treatment.

1. ____
2. ____
3. ____

4. Safety Issues

Are you seriously thinking about harming/hurting or killing yourself? ☐Yes ☐No ☐I don't know
Explain ____
***A life contract will be needed**

5.Medical History:

__Odd/Unusual Symptoms __Polio __HIV __Vascular __Chronic Ear Infections/Ear Tubes
__PMDD; Point in Menstrual Cycle __Infections/Viruses/High Fever __Visual __Lupus
__Skull/HeadmSurgeries/Deformities __Metabolic Disorders (e.g. diabetes) __Hypoglycemia
__Chemical Sensitivities __Thyroid __Allergies __Tinnitus __IBS __Strokes
__Heart Attacks __Viral Illness __Balance problems __Incontinence __Swallowing Problems
__Pulmonary __Endocrin __GI __Liver __Do you eat fish, meat, or fowl?
__Use Artificial Sweeteners/diet drinks? __Menopausal; Cravings:__________ __Chronic Pain: (0-10:)

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Allergies: Please list med allergies.____________________ Exposure to Toxic Agents (e.g., significant exposure to heavy metals, insecticides, carbon monoxide, solvents, drug overdoses, chemotherapy or radiation, etc.):

Neurological: __Neurological Disease; __Memory Difficulties (0-10:); __Seizures; __Confusion; __Restless Leg; __Apnea or daytime drowsiness; __Fatigue (0-10:); __Headaches or Migraines (0-10:); __ECT; __Accidents; __Coordination; __Tics/Twitches, Tremor, or Parkinson's; __Sensory Impairments; __Lyme; __Fibromyalgia; __# of Anesthetics; __Complicated Birth [forceps, fetal distress, complicated/prolonged labor, anoxia, Premature (Wt), prenatal drug exposure]; __Physical Abuse; __Sensitivity to Light & Sound; __Anosmia; __Oversensitive Smell; __Blows to the Head, Concussions, or Head Injuries (football, boxing, soccer, skateboarding, lacrosse, skiing, hockey, horseback riding; "see stars"); __Loss of Consciousness?
Total Number of Head Injuries; ____

Development: __Slow motor; __Slow speech; __Developmental delay; __Reading Problems (0-10:); __Math Problems (0-10: __Speech/Writing Problems (0-10:); School: __Below grade; __Special Classes; __Learning Disability; __Discipline Problem; __Concentration Problems (0-10:); __Disorganized (0-10:); __Forgetful (0-10:); __Impulsive (0-10:); Hyperactive (0-10:); __ADD (# of Criteria met ___) or ADHD (# of criteria met __);

Mental Status: __Depressed (0-10:); ___Suicide Attempts?; ____Withdrawn (0-10:); ___Anxiety (0-10:); ___Panic Attacks; ___Phobias; ___Bruxism; __Obsessive Rumination/Worry (0-10:); __OCD/ __Delusions, Hallucinations or Thought Disorder; __Mental Fogginess (0-10:); __Bipolar/Mood Swings (0-10:); __Reactive Attachment Disorder; __ODD; __Arrests; __Onset Insomnia (# mins:); __Frequent Awakening (#/night:); __Early Morning Awakening; __Autism; __Asperger's; __Sexual Addiction; __Compulsive Gambling; ___PTSD/Sexual Abuse; __DID/DDNOS;

6. CURRENT LIFESTYLE: Please list all medications, supplements or treatments for the mentioned concern.

Medication/Supplement Name	Dosage/Route		Frequency / Indication
______________________	__________	______	____________________
______________________	__________	______	____________________
______________________	__________	______	____________________
______________________	__________	______	____________________

LIFESTYLE (Family Genogram for additional information may be needed). ☐ Good ☐ Fair ☐ Poor (overall)

How is your appetite? ______ ______ ______ explain ____________
How many servings of caffeine/day? ☐ Yes explain ☐ No ____________
How many times do you exercise/week? ☐ Yes explain ☐ No ____________
How many hours of sleep/night? ____________
Do you smoke tobacco/Drug use? ☐ Yes explain ☐ No ____________
Do you drink alcohol? ☐ Yes explain ☐ No ____________
What do you do for enjoyment? ____________________________
How do you relax? ____________________________

7. Traumatic Stress: Please check any of the following you've experienced in the last 3 months.

	No	Yes
A traumatic event or memory that comes back in thought, nightmares, flashbacks, or any feelings? ______________________	☐	☐

8. Difficulties with Attention/Work/Schooling: Please check any of the following you've experience in the last 3 months.

	No	Yes
Difficulty concentrating or paying attention to detail for at least 6 months or longer	☐	☐
Felt or were told you were hyperactive, impulsive, or too restless	☐	☐
Have a hard time getting things done or attempting to do too much at once	☐	☐
Do you find these difficulties make work, school, or other obligations very difficult?	☐	☐

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Part 2. SENSTIVITY Questionnaire

(Frequency: How frequently you experience the symptom ("0" means not at all, "10" means all the time.

	0-10
I feel when the weather is about to change	
I can tell if a medication is going to work	
I can sense unhealthy environments and then take care of myself	
I can send my need for food before I feel hungry	
I can sense smells and scents that others seem not to notice	
I can feel myself getting a cold or flu prior to having symptoms	
I have a wide appreciation for tastes in different foods	
I can feel the difference between quietness and stillness	
I can feel the difference between relaxation and comfort	
I select my friends by how I feel when I am with them, rather than by appearances	
I sense mood, energy shifts and attention changes in people	
I need to do things at my own pace	
I am very creative	
I know quickly when something is going to work out, such as a job or relationship	
I have some abilities that some people consider psychic	

Reactivity:

	0-10
I have unpleasant reactions to certain weather changes.	
I have unpleasant reactions to certain foods.	
I have unpleasant reactions to certain medications.	
I have unpleasant reactions to certain smells.	
I have unpleasant reactions to certain sounds and lights.	
I have unpleasant reactions to skipping meals.	
I can be shocked by my reactions.	
My friends and family find me difficult being around.	

Hardiness:

	0-10
I have severe problems with the weather.	
I have little if any physical energy/stamina.	
I can do little thinking/planning without getting tired.	
I have great problems with foods.	
I have problems with medication (s).	
I get upset easily	
Pain prevents me from working	
When life hits me hard, it takes me a very long time to get back on my feet	

Part 3 -CENTRAL NERVOUS SENSITIVITY Questionnaire

For the symptoms below, indicate the following:

Frequency: How frequently you experience the symptom ("0" means not at all, "10" means all the time)
Parents: Check the box if you know whether one or both of your biological parents had the problem
Suddenly: Check the box if the symptom came on suddenly

Sensory	Frequently 0-10	Parents?	Suddenly?
Light, in general, or lights, bother you		☐	☐
Problems with sense of smell		☐	☐
Problems with vision		☐	☐
Problems with hearing		☐	☐
Problems with sense of touch		☐	☐
Emotions			
Problems with sudden, unexplained changes in mood		☐	☐
Problems with sudden, unexplained fearfulness		☐	☐

Problems with unexplained spells of depression		☐	☐
Problems with unexplained spells of elation		☐	☐
Problems with explosiveness		☐	☐
Problems with suicidal thoughts or actions		☐	☐
Clarity			
Feeling "foggy" and have problems with mental clarity		☐	☐
Problems with following conversations (with good hearing)		☐	☐
Problems following what you are reading		☐	☐
Realizing you have no idea what you have been reading		☐	☐
Problems with concentration		☐	☐
Problems with attention		☐	☐
Problems with sequencing (i.e., putting things in order)		☐	☐
Problems with prioritizing		☐	☐
Problems with not finishing what you start		☐	☐
Problems organizing your room, office, or paperwork		☐	☐
You cover that you don't know what was said or asked of you		☐	☐
Energy			
Problems with stamina		☐	☐
Fatigue during the day		☐	☐
Trouble sleeping at night		☐	☐
Problems awakening at night		☐	☐
Problems falling asleep after waking up		☐	☐
Activation/Anxiety			
Restlessness		☐	☐
Problems with irritability		☐	☐
Daydreaming		☐	☐
Worrying		☐	☐
Always moving		☐	☐
Cold hands or feet		☐	☐
Palpitations		☐	☐
Easily upset		☐	☐
Memory			
Forgetting what you just heard		☐	☐
Forgetting what you are doing or what you need to do		☐	☐
Problems with procrastination or lack of initiative		☐	☐
Problems not learning from experience		☐	☐
Movement			
Problems with paralysis of one or more limbs		☐	☐
Problems focusing your eyes		☐	☐
Pain			
Head pain that is steady		☐	☐
Head pain that is throbbing		☐	☐
Shoulder and neck pain		☐	☐
Wrist pain		☐	☐
Tender areas of muscles		☐	☐
Pain all over your body		☐	☐
Joint pain		☐	☐
Other pain (please specify)		☐	☐

Part 4 -Incomplete problem Resolution Questionnaire **Please answer yes/no and past or present**

Sensitivity/Reactivity	**YES**	**NO**
Unpredictable things had a big effect on me.	☐ past ☐ present	☐ past ☐ present
Situations were embarrassing for me.	☐ past ☐ present	☐ past ☐ present
Friends/Family had a hard time being around me.	☐ past ☐ present	☐ past ☐ present

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I was troubled by emotions/feelings.	☐ past ☐ present	☐ past ☐ present
I had problems like seizures, tics, migraines, headaches, cluster headaches, stuttering, Touretes, explosiveness	☐ past ☐ present	☐ past ☐ present

Extra Information to share:

____

____

Informed Consent for Neurofeedback

This document contains important information about Neurofeedback (also known as EEG biofeedback) and the policies implemented by the organization or related to the services of Neurofeedback. By signing this informed consent, I am satisfied with the information I have been provided (verbal, written or otherwise) by my trainer on the effects, or what to expect.

1) I am aware that of some benefits and risks of Neurofeedback, I am aware that it has been used for a variety of conditions and the process has also shown promise with certain behavioral disorders; sleep disorders, depression, anxiety, chronic pain, minor head injury and seizure disorder. It is understood that no representation is made that every client will improve from treatment, with the trainer's_ assistance, various studies in the literature it is understood, that the positive effects of Neurofeedback has assisted in brain health that the client has, on occasion, sought a few "tune-up sessions" months and years later. It is unclear the amount of needed of sessions. In regards, to risks or harm, there is no evidence, either from our experience or from the literature and research, that sessions are harmful. It is understood that it is non-invasive and painless. Some clients have reported that training could cause some temporary worsening symptoms; such as feeling more anxious, heavy legs or arms, being more distractible, having more difficulty sleeping, etc. It is further understood that these problems resolve quickly and on their own. Also, it is the responsibility to provide informed of any changes or negative effects, even if they seem unconnected to the Neurofeedback, so that training can be modified for you or that further medical support be acknowledged.

2) Neurofeedback and Medications: It is understood that I should disclose all medications taken and understand to not stop or alter your medications without consulting my physician. Also, I understand that Neurofeedback could affect my body's response to other medications you are taking for conditions and should any new symptoms appear, it is my utmost responsibility to keep us informed of them as well as to inform your physician.

3) Neurofeedback Procedures: I am aware that Neurofeedback training requires the placement of surface electrodes on the scalp for the express purpose of recording the EEG and using this signal to provide feedback to the brain via an electrical pulse or auditory stimulus, that there may be a possibility of a skin irritation from the application cream. If any discomfort it is my obligation to inform the trainee at any time of the session. It is understood that the equipment and preparation supply are followed by certain guidelines and are medical grade materials. The client can remove the electrodes at any ""discomfort" time if they so desire. It is understood that there is NO risk/or application of electric shock from this procedure.

4) Schedule and Length of Treatment Sessions: I understand that there are initial intake form/s will be administered and post follow up questionaries are done. Treatment sessions are varied, and individual specific especially if there are talk sessions in between. The neurofeedback can take seconds with LENS or take approximately 45 minutes NeurOptimal in length; with additional time for active talk 30 minutes (approximately) pre-test and post-test. It is suggested one/two times per week and the total average length of sessions will vary, depending on case specifics, or for general wellbeing maintenance. It is understood that changes can be experienced after just a few sessions or after all sessions, for even more than the

suggested 10 sessions of care.

5) Fees Neurofeedback: I am responsible to pay $95.00 per session after each completed session. In some cases, if extra talk session, or discounts or packages the fee schedule will vary. Lens will offer a topographical head map (included in the sessions) but will be only available after a full head sessions are obtained (2sets of 3 to 4 sessions) A full assessment session may include: Intake, Initial education of Neurofeedback, Full History Interview, follow up discussions, check in discussions/questions, topographical head map discussion (LENS), tools or resources to assist with condition/ concern. I understand that an invoice will be provided, however no guarantee of insurance company reimbursement and it is the sole responsibility of the client. Some insurance companies will not reimburse you for EEG Biofeedback (Neurofeedback) services. It can also be submitted for income tax benefits.

6) Missed Appointments: A Missed Appointment Fee of $50 will be charged for any missed appointments or cancellations later than 9:30am of the business day prior to your appointment. (A business day is defined as Monday to Friday, excluding holidays) and that it is my responsibility to re-schedule.

7) Clinicians and Technicians: It is understood, all technicians have proper training and are done in a professional manner and with your utmost care in mind. All our technicians report, via careful clinical notes which are stored at a third party and off site.

8) Affiliations and Consultation: If there are any affiliations or associations with the form of care, the technician can disclose, with the permission of you, the client the technician and may consult with professionals in another affiliate group and/clinics. This consultation is done to provide an even better experience and treatment outcome to the client. At no time will any staff or professional disclose information, unless specific written consent is given by you.

9) Clinic Policy and Procedure Manual: It is agreed that there are policy and procedures implemented by the clinic and procedures which also have to be abideded by or by the Ministry of Health (covid procedures).

Please initial the following items to indicate that you have read, understand and been offered the opportunity to discuss any questions that you have pertaining to these items with your Technician or staff member.

By signing this form, you indicate your understanding of the principles set forth here in regard to:
__ 1) benefits and risks; ___ 2) medications; ____ 3) procedures; ___ 4) expectations with regard to length of treatment; ___ 5) fees; ____ 6) policies with regards to appointments; ___ 7) comfort with technician/ clinician administering; _____ 8) consultation option with other professionals; ___ 9) Following Clinic Policy and Procedure Guidelines ____

Furthermore, by signing this form you waive any claim of damages due to the training, including worsening of the condition for which the training was undertaken, claimed side effects or the failure to improve with training. In addition, you agree to the organization/clinic where it is being serviced and its associates harmless from all claims associated with such training.

I understand the above information and agree to its terms:

Patient Name:____________________ Patient Signature:______________________ Date:_______________________