Echo Rock Neurotherapy

Date: _____

Name: _____ **Age**: _____

Address: _____ **Cell Phone**: _____

City, ST Zip: _____ **Accept Txt Messages?** ☐ Yes ☐ No

Email: _____ **Other Phone**: _____

Profession: _____ **Prof Title**: _____

Where did you hear about us? _____

Have you had neurofeedback before? ☐ Yes ☐ No **Present stress level**: _____

Doctor/healthcare practitioner name and # _____

Ready to release:

- ☐ negative thought loops
- ☐ foggy thinking
- ☐ distractedness
- ☐ overwhelm
- ☐ irritability
- ☐ pain
- ☐ depression
- ☐ low energy
- ☐ inability to sleep
- ☐ anxiety
- ☐ forgetfulness
- ☐ low confidence
- ☐ restlessness
- ☐ procrastination
- ☐ migraines or headaches/tremors
- ☐ ADHD
- ☐ PTSD
- ☐ addictions
- ☐ arguments
- ☐ fears
- ☐ speaking without thinking

Ready for more:

- ☐ clarity
- ☐ energy
- ☐ calm
- ☐ contentment
- ☐ confidence
- ☐ awareness
- ☐ concentration
- ☐ wisdom
- ☐ feeling safe
- ☐ joy
- ☐ connection
- ☐ gratitude
- ☐ happiness
- ☐ organization
- ☐ task completion
- ☐ live in the present
- ☐ quiet mind
- ☐ steadiness
- ☐ patience
- ☐ kindness

Prioritize Issues:

1. _____ 2. _____ 3. _____

About how many times have you ever hit your head? (work and sports bumps, whiplash, accidents, etc): _____

List and date these head traumas: _____

BODY RECEPTIVITY **How often are you BOTHERED by these? (0 = never, 10 = always)**

1. My body lets me know when the weather (barometric pressure) changes. _____
2. I have allergies or problems eating some foods, like_____ _____
3. My body is permeable to the environment, such as fluorescent lights. _____
4. I am the first one in the room bothered by smells, noise, lights or temperatures. _____
5. I respond strongly to a lower-than-normal dosage of medicine or herbs. _____
6. I am hypersensitive to my environment or startle easily. _____

REACTIVITY **How often are you BOTHERED by these? (0 = never, 10 = always)**

1. I have an explosive temper or friends/family find me intense to be around. _____
2. I am sometimes shocked by the intensity of my reactions. _____
3. I have had: (circle) seizures, tics, migraines, stroke, Parkinson's, Alzheimer's, ADHD.
4. I have (circle) very low blood pressure or fainting spells.

RESILIENCE **Frequency (0 = never, 10 = always)**

1. I feel fine with weather changes. _____
2. I have great endurance or can work long hours. _____
3. I have deep internal resources and good external support. _____
4. When life hits me hard, I recover quickly. _____
5. I have the strength to tolerate difficult sensations. _____
6. I exercise at least twice a week. _____
7. I meditate (circle): daily, weekly, silent retreats _____
   Total lifetime hours:_____

List drugs taken and diagnosis: _____

I am in stable medical condition, with no recent new treatment modalities or medications. ☐ Yes ☐ No
I understand that LEN may make my body more efficient at utilizing drugs and will consult my doctor about drug overdose symptoms. I use (circle): coffee, alcohol, herbs, supplements, marijuana, other: _____

How many 8oz. cups of water do you drink a day? _____

The CNS Functioning Assessment 0-10

Rate **how often** are you currently **bothered** by the following. **"0" means *Not at all*, and "10" means *All the time.***
Example: concentration = 7 (7/10ths of the time when you try to concentrate)

Clarity

__ Confusion
__ Foggy Thinking
__ Concentration
__ Sequencing
__ Finishing things
__ Problems reading
__ Following Conversations
__ Organizing
__ Remembering what was said or asked of you

Stamina

__ Daytime fatigue
__ getting to sleep
__ awakening

Anxiety and Activation

__ Restlessness
__ Irritability
__ day dreaming
__ Worrying
__ always moving
__ cold hands and feet
__ falling asleep again

Memory

__ Forget what you just read/heard
__ what you are doing
__ what you need to do
__ Problems with lack of initiative
__ Problems not learning from experience

Sensory

__ Problem with lights
__ Smell
__ Vision
__ Hearing
__ Touch

Emotions

__ Sudden, unexplained mood changes
__ Fearfulness
__ Depression
__ Elation
__ Anger
__ Problems with suicidal thoughts or actions

Movement

__ Problems with paralysis of one or more limbs
__ Problems focusing or converging the eyes

Pain

__ Steady headache
__ throbbing headache
__ neck and shoulder pain
__ back pain
__ All-over pain
__ Other pain (specify): _____

I am normally not able to (circle): drive a car, work, study, sustain a friendship, live with a partner.

Please sign the back of this page.

Echo Rock Neurotherapy LENS Treatment Consent

Areas of applicability: The LENS (Low Energy Neurofeedback System) has been successfully applied to central nervous system problems, such as symptoms of traumatic brain injury, stroke rehabilitation, fibromyalgia, depression and other mood and anxiety disorders, attention, hyper-activity, explosiveness/anger, and learning problems. Controlled studies on the LENS have been and are being conducted. Several university and medical human subjects review committees have reviewed the LENS treatment and have found it to be "minimally invasive."

Effects of The LENS: The LENS tends to make functioning clearer and easier. It has increased cognitive functioning (memory, concentration, attention, ability to learn and to read, organizing, and sequencing), motivation (initiating and completing activities), energy and stamina, motor skills (coordination, balance, grace, recovery from paralysis). It has elevated mood as an antidepressant. It has improved sleep at night, and reduced sleepiness during the day. It has increased. It has reduced seizures, explosiveness, irritability, spasticity, and background anxiety, migraine and fibromyalgia pain, as well as Restless Legs problems.

Side Effects: Although no significant negative side effects have been observed so far, effects we have seen will be discussed with you by your LENS Clinician. Understanding them will help you work with us to provide successful treatment. The side effects sometimes seen with the LENS are *temporary* increases in previous symptoms. Let your LENS Clinician know your exact experience so that he/she can work closely with you to adjust the dosage. This is done the same way your medications are adjusted by your physician.

Medical Stability: You must be medically stable to engage in this treatment. Please tell your Clinician if you have any changes in medication, but especially any changes that could affect your medical stability. At times, your medical stability may be increased by reducing your medication. Your Clinician will ask you to consult your physician in these instances.

Other Treatments: Although service providers at Echo Rock may be Licensed Marriage Family Therapists, they often provide only neurofeedback, meditation guidance, and/or lifestyle advice. In these cases, state laws about psychotherapy do not apply and information about you may not be confidential.

Discontinuing Treatment: You may discontinue treatment at any time for any reason. Should you wish to discontinue treatment, please inform your Clinician. He or she will cooperate and provide copies of any records for another therapist.

Privacy: Your treatment records are private to the fullest extent of the law; that is, except in cases of potential harm to yourself or others, or in civil or criminal proceedings and with a court order.

Because people are individuals, success with the LENS is best predicted with a complete evaluation and the development of a treatment plan. The evaluation allows us to predict which symptoms will respond, and which may respond first. As with any treatment, there can be no guarantee of success in any particular instance. You are therefore invited to consent to be treated on the basis of this information. Before you give your consent, we want you to ask as many questions as are necessary for you to understand this process. Please continue to express your questions, observations, and concerns at any time during the treatment process.

Consent to Treatment: I have been informed of the effects, side effects, benefits, and risks of this treatment, and give my consent to participate in it.

Payment: Due at time of service. Cash Discount is $10/session. Initial interview may take a full hour. Payment is due for sessions canceled less than 48 hours before the appointment.

□ Please limit non-personal emails such as newsletters to one time per month maximum.

Print Name	Signature	Parent (if under 18)	Date