Welcome to Body & Brain Centre!

Name: _____ **DOB:** _____ **Age:** _____

Address: _____ **Suburb:** _____ **Postcode:** _____

Phone: _____ **Mobile:** _____ **Occupation:** _____

Email Address: _____ **Hobbies:** _____
Please Tick: ❒ I would like to receive newsletters with special offers, health tips and more.

Emergency Contact - Name: _____ **Phone:** _____ **R'ship:** _____

Children / Siblings Names & Ages: _____

Who can we thank for referring you? _____ PS they will get a thank-you voucher

If online, what search words were used? _____

Have you had neurofeedback previously? Yes / No **Last Treatment:** _____

Name of Previous Practitioner: _____

Please describe your present condition/s.
Condition 1: _____
_____

Condition 2: _____
_____

Condition 3: _____
_____

	When Did it Start? Date or days, months, years	**How Often do you Experience it?** 0% = never, 100% = always	**How Long Does it Last?**	**Improves with …** activities, thoughts, support, etc	**Worse with …** activities, thoughts, experiences, etc
Condition 1					
Condition 2					
Condition 3					

Physical
Chiropractic
Myotherapy
Remedial Massage

Brain
Biofeedback
Neuro-Rehab
Brain Scans

Emotional
Counselling
Meditation

Nutritional
Dietetics/Nutrition
Naturopathy

Traditional
Acupuncture
Chinese Medicine

How do you rate your: General wellbeing ___/10 **Why?** _____

Diet ___/10 ❒ 5 vegetables daily ❒ fruit daily ❒ protein at each meal ❒ "junk" food daily
How much do you drink daily: Water? _____ **Coffee?** _____ **Tea?** _____ ❒ Herbal only
How do you respond to caffeine? ❒ Required to function ❒ Sensitive to effects ❒ No change
How do you feel after a meal? ❒ Energised ❒ Fatigued ❒ No Change **Alcohol Weekly:**_____

Have you ever smoked? ❒ Current ❒ Past ❒ Never **How long?** ____ **How many daily?**_____

Exercise ___/10 **Typical exercise routine:**
Type: _____ Intensity / Distance: _____ Frequency: ____per week
Type: _____ Intensity / Distance: _____ Frequency: ____per week

Sleep ___/10 ❒ Trouble getting to sleep ❒ Snore ❒ Restless sleeper ❒ Use an alarm to wake up
❒ Wake up in the night (___ times per night, waking up at ____ time) ❒ Vivid dreams ❒ Night terrors
❒ Sleep lightly **Awake Feeling:** ❒ Tired ❒ Alert **Do you have a consistent routine?** ❒ Yes ❒ No
What time do you: Go to bed? _____ **Get to sleep?** _____ **Wake up?** _____

Stress ___/10 **Experience stress:** ❒ Frequently ❒ Sometimes ❒ Rarely
Biggest Source of Stress: ❒ Work ❒ Personal ❒ Other _____ ❒ Everything
How do you relax? _____

Mood ___/10 **Why?** _____

Please list any medication (including supplements, contraception & recreational drugs):
Current: _____
Significant Previous: _____

Please list any surgeries you've had & when: Surgery: _____ Year: _____
Surgery: _____ Year: _____ Surgery: _____ Year: _____

Please Outline Any Accidents You've Had & When: Include hits to the head, accidents, falls, etc
Incidence: _____ Year: ____ Incidence: _____ Year: _____
Incidence: _____ Year: ____ Incidence: _____ Year: _____

Have <u>you</u> suffered any major or recurring conditions? *This information is vitally important. Please fill it in and add in any further details.*
❒ Heart attack / disease ❒ Blood clots ❒ High / low blood pressure ❒ Fainting ❒ High cholesterol
❒ Skin concerns ❒ Diabetes ❒ Thyroid ❒ Hormonal concerns ❒ Anxiety ❒ Depression ❒ Genetic
❒ Gut issues (constipation, diarrhoea, bloating, pain) ❒ Osteoporosis ❒ Arthritis ❒ Muscle cramps
❒ Twitches ❒ Loss of muscle strength ❒ Cancer ❒ Dementia ❒ Seizures ❒ Learning difficulties
❒ Serious infections ❒ Any illness in last 3 weeks ❒ Hospitalisation in the last 5 years
Other / Details: _____
_____
_____

Allergies / Sensitivities: _____

Has someone in <u>your Family</u> suffered any major or recurring conditions? Please indicate relationship to you for each condition in your family history. Examples as listed above.
Maternal: _____
Paternal: _____
Siblings: _____

Informed Consent for Neurofeedback Training

I hereby authorise Dr Cassie Atkinson-Quinton (Chiropractor), or practitioners under her supervision, to provide me with neurofeedback training.

I understand that this training is used for a variety of conditions, which appear to be associated with irregular brain activity, including but not limited to:

- Migraines & headaches;
- Chronic pain;
- ADHD;
- Depression / Anxiety;
- Stroke; and
- Cognitive & Sporting Performance

Training is recommended on the basis of scientific research and empirical observation of improvement in clients with similar conditions.

What to expect during and after neurofeedback

I understand that EEG biofeedback (neurofeedback) requires placement of surface electrodes on my scalp for the purpose of recording my EEG and the use of this signal to provide video displays and audio signals.

I understand that some individuals have reported that training may affect my body's response to medications for my condition and for unrelated conditions. I understand that I should not stop or alter any of my medications without consulting my GP / prescribing practitioner. I should continue ongoing therapies until otherwise advised by the doctor. Should new symptoms develop, it is my responsibility to inform my health care providers including my neurofeedback practitioner.

I understand that it is the client's own responsibility to monitor the subjective effects of training. Neurofeedback is based on the input of the client's report from day to day sessions as well as from the initial evaluation and depends on the full participation of the client i.e. his/her feedback about the effects of the training on you (or your child). The research literature indicates that there are some individuals who are apparently unaffected by training. Accordingly, the client is encouraged to evaluate progress after about ten sessions to determine if further training is indicated. Discussion is invited at this point or any time during the training.

No representation is made that any individual client will improve from training. There is some indication that some client's improvement may fall off after the cessation of training. These individuals would benefit from periodic follow-up or booster sessions. The training is non-invasive and appears to be a harmless procedure as far as is known at present. No injuries are known or reported in the literature.

Other treatment options include, but is not limited to, pharmacological interventions (pain killers, anti-inflammatories or other medication) and other therapies such as psychology, occupational therapy, etc. Adherent risks include, but is not limited to, irritation of the stomach, liver or kidneys & dependance issues to medication.

Research studies and presentations are performed from time to time within the centre. This assists us deliver the best quality care and to educate fellow practitioners. All identifying information is removed and your involvement doesn't change your management plan. Participation is voluntary and consent may be revoked at any time. There are no additional risks associated with being involved in the centre collecting your de-identified clinical information.

PLEASE DO NOT SIGN UNTIL YOU HAVE SPOKEN TO YOUR PRACTITIONER.

Please Tick

☐ The information provided is accurate and fully inclusive to the best of my knowledge. I understand the advice and treatment plan is made on the information that I provide. I will update my practitioner on any medical conditions or health concerns as they arise.

☐ I hereby request and consent to brainwave (EEG) analysis and neurofeedback therapy. I understand that I can withdraw my consent at any time.

☐ I hereby consent for my de-identified information to be used in research and presentations and BBC.

☐ I understand I must provide 24 hours notice if I'm unable to attend my scheduled appointment to avoid paying a 50% cancelation fee. If I fail to provide notice that I cannot attend my appointment, I will be liable for 100% of the consultation fees. I also understand that all fees are payable on the day of consultation.

SIGNATURE_____

DATE_____

PRINT NAME_____
(Parent/Guardian if under 18 years)

PRACTITIONER: _____
Own behalf of any current or future practitioners of Body and Brain Centre