Functional Integrative Practice of Dr. Nadia Ali
Functional Holistic Healing
175 Strafford Ave, Suite one
Wayne, PA, 19087
Ph: 610-363-3973
Fax: 484-631-1327
website: www.theholistichealing.org

About IASIS MCN:

MicroCurrent Neurofeedback

Intake Forms

Name: _____

Email Address: _____

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NEUROFEEDBACK ASSESSMENT

Date of assessment: ___/___/___

Name: (Last) _____ (First)_____ (MI)_____

Date of Birth: __/__/__ Age: ___ Sex: ___

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) ____._____ Email: _____

Legal Guardian: _____

(If patient is a minor)

School/Grade: _____

(If applicable)

Occupation: _____

Emergency Contact: _____

Phone: (____) ____._____

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My five most prominent symptoms are:

1.
2.
3.
4.
5.

PERSONAL HISTORY:

1. PAST MEDICAL HISTORY (Please list any illness/diagnosis, physical injury, head injury – brain injury/concussion/whiplash/falls, surgeries):

_____

_____

_____

_____

2. MEDICATIONS (please include supplements):

NAME	DOSE	REASON FOR TAKING
1.		

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2.		
3.		
4.		
5.		

3. ALLERGIES (please list medication and food allergies):

MEDICATION	FOOD	REACTION
1.		
2.		
3.		
4.		
5.		
6.		

4. FAMILY HISTORY (G = grandparents, P = parents, S = self):

Cancer G P S	**Thyroid G P S**	**Mental illness G P S**
Heart disease G P S	**Diabetes G P S**	
Lung disease G P S	**Autoimmune G P S**	

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Other (please describe):

_____

_____

5. SOCIAL HISTORY (Y = yes, N = no, P = past):

Alcohol Y N P	**Antacids Y N P**	**Addiction Y N P**
Smoking Y N P	**Laxatives Y N P**	
Steroids Y N P	**Pain meds Y N P**	

Addiction treatment(s):_____

6. EMOTIONAL HISTORY (Y = yes, N = No, P = past):

Anxiety Y N P	**Anger Y N P**	**Panic Y N P**
Depression Y N P	**Irritability Y N P**	**Abuse history Y N P**
Insomnia Y N P	**High strung Y N P**	**Food addiction Y N P**
Suicidal Y N P	**Fear Y N P**	**Eating disorder Y N P**

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PTSD Y N P	**Guilt Y N P**	**OCD Y N P**

Additional comments:

_____

REVIEW OF SYMPTOMS:

1. PAIN:

A. Headaches:

➢How often? _____ **➢Location?** _____

➢Severity? _____

➢Triggers: _____

➢History of Migraine headache? Yes No

B. Body/joint/limb pain? Please describe:

_____

_____

➢What makes your pain better _____

➢What makes your pain worse? _____

➢Fibromyalgia? Yes No

➢Photophobia (sensitivity to light) Yes No

➢Hyperacusis (sensitivity to/pain from sound)? Yes No

2. SLEEP:

➢Do you have difficulty falling asleep? Yes No

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➢**Do you have difficulty staying asleep? Yes No**

➢**How many hours do you sleep per night? _____**

➢ **How many hours' sleep do you need? _____**

➢**Do you wake feeling rested? Yes No**

➢ **Nightmares? Yes No**

Additional comments:

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3. <u>FOCUS/CONCENTRATION/MEMORY</u>:

➢**ADD/ADHD? Yes No Medication/Treatment: _____**

➢**Poor concentration? Yes No** ➢**Impulsivity? Yes No**

➢**making decisions? Yes No** ➢**Disorganized? Yes No**

➢**Easily distracted? Yes No** ➢**Racing thoughts? Yes No**

➢**Overwhelmed by stimuli? Yes No**

4. <u>NEUROLOGICAL</u>:

➢**Seizures? Yes No** ➢**Type: _____**

➢**Stroke? Yes No** ➢**Location: _____**

➢**Tremors? Yes No** ➢**Poor balance? Yes No**

➢**Traumatic Brain Injury? Yes No** ➢**Vertigo? Yes No**

➢**Tinnitus (ringing in the ears)? Yes No** ➢**Hearing loss? Yes No**

5. <u>IMMUNE/ENDOCRINE/AUTONOMIC NERVOUS SYSTEM</u>:

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➢**Immune deficiency?** **Yes** **No**

➢**Adrenal insufficiency?** **Yes** **No**

➢**Chronic Fatigue Syndrome?** **Yes** **No**

➢**Asthma?** **Yes** **No**

➢**Multiple Chemical Sensitivities?** **Yes** **No**

➢**Irregular Menstrual Periods?** **Yes** **No** ➢**Menopause?** **Yes** **No**

➢**Premenstrual Syndrome (PMS)?** **Yes** **No**

➢**Constipation?** **Yes** **No**

Additional comments:

_____

_____

PRACTITIONER NOTES:

_____

_____

_____

_____