mind potential northwest, llc

personal & professional development
performance training & neurotherapy

STATEMENT OF PROFESSIONAL DISCLOSURE

Clinician Name: Darla Meulemans, MA, CADC III, QMHP-C, EEG-OMC (2015)
Business Name: Mind Potential Northwest, *LLC*
Office Address: 5200 S Macadam Avenue, Suite #160
Portland, Oregon
Mailing Address: PO Box 68056
Portland, OR 97268
Phone: (503) 757-9557

Philosophy and Approach: Personal and Professional Development Programs, as well as Performance Training, Neurotherapy, and Holistic Nutrition Coaching Services, combine cutting-edge neuroscience strategies with practical, natural remedies and the timeless wisdom of the ages. Based on the belief that every human being has within them the capacity to experience wellness and balance -- wisdom and peace, service designed to return clients to their natural, underlying state of security, cognitive flow, and emotional well-being. As a result, clients begin to recognize their capacity for a healthy and productive way of being and learn to identify and overcome patterns that obstruct their experiences of enjoyment, clarity, inspiration, relaxation, creativity, and overall health.

Qualifications: Darla holds a M.A. degree in Counseling Psychology, and has specialized training in Addiction Behavior Medicine, EEG Biofeedback (Neurotherapy), and Holistic Nutrition Coaching. She is a member of the Association for Applied Psychophysiology and Biofeedback, a master's level Certified Alcohol and Drug Counselor, a Certified Qualified Mental Health Professional, a Holistic Nutrition Specialist, and an Othmer Method Neurofeedback Practitioner. Since 1995, Darla has had experience working with individuals, couples, families, and businesses. She abides by the Code of Ethics for Helping Professionals and receives professional training & supervision, as needed.

All fees are due at the time of service (cash or check preferred, 4% service charge for Credit Cards), unless previous payment arrangements have been agreed upon. Insurance is not accepted or directly billed, but you can request a Service Invoice with appropriate procedure codes for reimbursement from some Insurance Companies and/or a Health Savings Account.

As a client, you have the following rights:

- ✔ To expect that I have met the minimal qualifications of training and experience required by law;
- ✔ To examine records to confirm education and credentials;
- ✔ To obtain a copy of the Code of Ethics;
- ✔ To report complaints to the American Counseling Association, and/or the Better Business Bureau;
- ✔ To be informed of the cost of professional services before receiving the services;
- ✔ To be assured of privacy, confidentiality and ethical care while receiving services as defined by rule and law, free from being the object of discrimination on the basis of race, religion, age, gender, sexual orientation or other unlawful category while receiving services.

mind potential northwest, llc

personal & professional development
performance training & neurotherapy

STATEMENT OF PROFESSIONAL DISCLOSURE

Clinician Name: Dr. Noel Thomas, N.D.

Business Name: Independent Contractor with Mind Potential Northwest, *LLC*

Office Address: 5200 S Macadam Avenue, Suite #160
Portland, Oregon

Phone: (503) 248-1182

Philosophy and Approach: Dr Thomas provides coverage for Neurofeedback sessions when Darla Meulemans is not available. Her practices and protocols are fully in alignment with Mind Potential Northwest's disclosure for providing Neurofeedback Brain Training.

Qualifications: Dr. Noël Thomas is a board-certified and licensed naturopathic physician who specializes in holistic approaches to healing including nearly 25 years providing neurofeedback. Her study and use of functional neurology began in 2012 because she feels that, "Therapies that improve brain function improve all of the body's systems." Dr. Thomas is a member of the following organizations: American Association of Naturopathic Physicians, EEG Institute, Ochs Labs, International Association of Functional Neurology and Rehabilitation, Weston A. Price Foundation, and International College of Applied Kinesiology.

All policies, procedures, and protocols are consistent with Mind Potential Northwest.

As a client, you have the following rights:

- ✔ To expect that I have met the minimal qualifications of training and experience required by law;
- ✔ To examine records to confirm education and credentials;
- ✔ To obtain a copy of the Code of Ethics;
- ✔ To report complaints to the American Counseling Association, and/or the Better Business Bureau;
- ✔ To be informed of the cost of professional services before receiving the services;
- ✔ To be assured of privacy, confidentiality and ethical care while receiving services as defined by rule and law, free from being the object of discrimination on the basis of race, religion, age, gender, sexual orientation or other unlawful category while receiving services.

mind potential northwest, llc

personal & professional development
performance training & neurotherapy

STATEMENT OF PROFESSIONAL DISCLOSURE

Clinician Name: Briant Nierstedt, MA, QMHP-C, BCIA

Business Name: Independent Contractor with Mind Potential Northwest, *LLC*

Office Address: 5200 S Macadam Avenue, Suite #160
Portland, Oregon

Phone: (503) 407-8650

Philosophy and Approach: Briant provides coverage for Darla when she is not available or when he is a better fit for the clients needs. His approach and protocols are fully in alignment with Mind Potential Northwest's disclosure and providing Personal Development and mentoring Services, as well as Neurofeedback Brain Training.

Qualifications: Briant holds a M.A. degree in Counseling Psychology, and has specialized training in behavioral health and EEG Biofeedback. He is a member of the Association for Applied Psychophysiology and Biofeedback, a master's level Certified Qualified Mental Health Professional, and a Board Certified Practitioner with The Biofeedback Certification International Alliance(BCIA). Briant has over 30 years of experience working with individuals or all ages navigating mental health-related challenges. He abides by the Code of Ethics for Helping Professionals and receives professional training & supervision, as needed. Briant is an Associate Neurofeedback Technician and Contracted Consultant with Mind Potential Northwest, LLC.

All policies, procedures, and protocols are consistent with Mind Potential Northwest.

As a client, you have the following rights:

- ✔ To expect that I have met the minimal qualifications of training and experience required by law;
- ✔ To examine records to confirm education and credentials;
- ✔ To obtain a copy of the Code of Ethics;
- ✔ To report complaints to the American Counseling Association, and/or the Better Business Bureau;
- ✔ To be informed of the cost of professional services before receiving the services;
- ✔ To be assured of privacy, confidentiality, and ethical care while receiving services as defined by rule and law, free from being the object of discrimination on the basis of race, religion, age, gender, sexual orientation, or other unlawful category while receiving services.

mind potential northwest, llc

personal & professional development
performance training & neurotherapy

STATEMENT OF PROFESSIONAL DISCLOSURE

Clinician Name: Virginia Rojas-Albrieux, Psychologist, Othmer Method Certified

Business Name: Independent Contractor with Mind Potential Northwest, LLC

Location: REMOTE TRAINING ONLY

Phone: +57 (315) 311-8068

Philosophy and Approach: Virginia provides coverage for distance/remote neurofeedback clients who have a system and are training in their homes. Her approach and protocols are fully in alignment with Mind Potential Northwest's disclosure for providing Neurofeedback Assessment & Remote Brain Training.

Qualifications: Virginia Rojas Albrieux is a psychologist residing in Colombia, South America, who has been involved with neurofeedback since 2006, training children and adults in her practice. Virginia is a contracted provider for Mind Potential Northwest, where she conducts remote Neurofeedback sessions for English and Spanish-speaking clients. Additionally, she provides training and mentoring to Neurofeedback clinicians throughout Latin America, Europe, India, and the US, both in English and Spanish. Virginia holds additional studies in Mind/Body medicine and neuropsychology, is particularly interested in developmental trauma, and is very passionate about neuroscience, nutrition, and brain health. She abides by the Code of Ethics for Helping Professionals and receives professional training & supervision, as needed.

All policies, procedures, and protocols are consistent with Mind Potential Northwest.

As a client, you have the following rights:

- ✔ To expect that I have met the minimal qualifications of training and experience required by law;
- ✔ To examine records to confirm education and credentials;
- ✔ To obtain a copy of the Code of Ethics;
- ✔ To report complaints to the American Counseling Association, and/or the Better Business Bureau;
- ✔ To be informed of the cost of professional services before receiving the services;
  To be assured of privacy, confidentiality, and ethical care while receiving services as defined by rule and law, free from being the object of discrimination on the basis of race, religion, age, gender, sexual orientation, or other unlawful category while receiving services.

☐ This is to confirm that I have read and understood the contents of this professional disclosure statement.

Client Signature Date

MIND POTENTIAL NORTHWEST, LLC NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) –Revised: November 7, 2022
(This notice describes how health information about you may be used and disclosed and how you can get access to this information).

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care services you receive at this office. Your health information may include information created and received by this office, which may be in the form of spoken words, written or electronic records, and may include information about your health history, health status, symptoms, examination, test results, diagnoses, treatment, procedures, prescriptions, related billing activity and similar types of health-related information. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describe your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about a service that you received here so your health plan will pay us or reimburse you for the service. We may also tell your plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

For Healthcare Operations: We may use and disclose health information about you in order to run the office and make sure that you and our patients receive quality care.

For example: We may disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at the office. Please notify us in writing if you do not wish to be contacted for appointment reminders.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services: We may tell you about health-related products or services that may be of interest to you. Please notify us in writing if you do not wish to receive communications about treatment alternatives or health-related products or services.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law: We will disclose health information about you when required to do so by federal, state, or local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher has access to your name, address, or other information that reveals who you are, or will be involved in your care at the office.

Military, Veterans, National Security and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefit for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reasons to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil right laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administration order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all application legal requirements.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner.

Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf, (ex-to have someone pick up medical supplies for you).

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION
We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific written *Authorization.* If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization,* but we cannot take back any uses or disclosures already made with your permission. In some instances, we may need specific, written authorization from you in order to disclose certain types of specialty-protected information such as HIV, substance abuse, mental health, and genetic testing information.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU
You have the following rights regarding health information we maintain about you:

Right to inspect and copy: You have the right to inspect and request a copy of your health information, such as medical and billing records. You must submit a written request to Mind Potential Northwest LLC: Attn: HIPAA Privacy Officer. If you request a copy of the information, we may charge a fee for related costs. In certain limited circumstances, we may deny your request to inspect and/or copy records. If you wish to contest the denial and the law gives you a right to have the denial reviewed, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied the request and we will comply with the outcome of the review.
Right to Amend: If you believe that the health information we have on file is incorrect or incomplete, you may ask us to amend the information. Your request must be made in writing and must explain why the information should be amended. If we did not create the information, you want amended or for certain other circumstances, we may deny your request. If we deny your request, we will provide a written explanation. If denied, you have the right to file a statement of disagreement with the decision which we will keep on file.
Right to Accounting of Disclosures: You have the right to request a copy of the list of disclosures we made of medication information about you for the purpose of your treatment, payment, health care operations, and a limited number of special circumstances involving national security correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization. Requests must be received in writing and must include a time period which may not be longer than 6 years and may not include dates before April 14, 2003. We may charge a fee for related costs.
Right to Request Restriction: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. We will comply with your requests unless the information is needed to provide you with emergency treatment, or we are required by law to use or disclose the information. All requests for restrictions must be received in writing.
Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at certain locations. For example, you can ask that we only contact you at work or by mail. All requests must be received in writing, and you must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE
We reserve the right to change this notice and to make the revised or changed notice effective for medical information we already have about you, as well as any information we receive in the future. You are entitled to a copy of the notice currently in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with our office and the Secretary of the Department of Health and Human Services. All complaints must be received in writing and will be reviewed and responded to as appropriate. You will not be penalized for filing a complaint.

The Mind Potential, LLC Compliance and Privacy Officer
Name: Darla Meulemans, MA **Address:** PO Box 68056, Portland, OR 97268
Phone: 503.757.9557

☐ This is to confirm that I have received and reviewed the policy and understand its application and limitations.

_____

Client Signature **Date**

MIND POTENTIAL NORTHWEST INFORMED CONSENT

Client Name:	DOB:

Initials

	I give my consent to receive personal development and/or Brain Performance Training or Neurotherapy services from Darla A. Meulemans, MA, CADC III. I understand that Darla has sufficient and appropriate education, training and experience in providing personal development coaching and Brainwave Training, including specialized training in mental health, addictions, EEG Biofeedback, Energy Medicine Protocols and EMDR.
	I understand that there may be times when a trained Associate Neurofeedback Technician or Counselor may provide the direct service. I understand that the Associate will be properly qualified, trained and mentored by Darla Meulemans, who will be overseeing all adjustments to my training protocols & therapeutic interventions.
	I have received a Professional Disclosure Statement for Darla Meulemans and understand the intention of services offered, her professional qualifications and limitations to insurance billing.

NEUROTHERAPY CLIENTS ONLY

	I understand that Neurotherapy (EEG Biofeedback / brainwave training) is used for a variety of conditions that appear to be associated with dysregulation in brain activity. These conditions include but are not limited to, sleep disturbances, mood disturbances, trauma, attention and focus difficulties, headaches and pain.
	I understand that Neurotherapy requires placement of surface electrodes on my scalp for the purpose of recording EEG data and the use of this signal provides video display, and audio & tactile output/feedback. The training is noninvasive and no injuries are known or reported.
	I understand that this is a trial and error process and protocols are intended to improve self-regulation in brain regions which are known to be responsible for specific function. Results vary and depend on many factors but adjustments are made each session to assist the client in being comfortable while reducing symptoms. If no improvement is experienced after 10 sessions, I am encouraged to discuss this with my Neurotherapist and determine if further training is indicated.
	I understand that some individuals have reported that training may affect the body's response to medications. I understand that I should not stop taking any prescribed medication or alter any of my medications without consulting with the prescribing practitioner. I should continue ongoing therapies until otherwise advised by my physician.
	I understand that Neurotherapy requires participation and feedback from the client regarding changes in day-to-day functioning, feelings, and symptoms, in order to evaluate the effects of the training & make clinical adjustments. It is my responsibility to inform my health care providers, including my Neurotherapist, should new symptoms develop after initiating EEG Neurofeedback.

By signing below, I waive any claim of damages as a result of services, including worsening of my condition, claimed side effects of Neurotherapy, or the failure to improve.

_____

Client Signature (If Over the Age of 14) Date

_____

Signature of Parent/Guardian of Minor Child Date

MIND POTENTIAL NORTHWEST CANCELLATION POLICY

Client Name: _____

_____ Initials I understand that if I am unable to attend a scheduled appointment, I must give a minimum of 24 hours advance notice to cancel or I may be charged the full fee for that session, if that appointment time cannot be filled. If I fail to cancel at all, and do not show up for the appointment, I will be charged the full fee for that session.

MIND POTENTIAL NORTHWEST STATEMENT OF CONFIDENTIALITY

_____ Initials I understand that as a client of Mind Potential Northwest, LLC all information that I share is privileged and will be kept confidential in accordance with state and federal laws, 42 CFR Part 2, & HIPAA. There are, however, certain exceptions in which helping professionals are required to report information to the appropriate authorities. These exceptions include the following:

1. Reporting suspected child or elder abuse;
2. Reporting imminent danger to self or others;
3. Reporting information required in court proceedings or by client's insurance company or payor, or other relevant parties;
4. Providing information concerning case consultation or supervision; and
5. Defending claims brought by client against Mind Potential Northwest, LLC.

My signature below demonstrates that I agree to the cancellation policy, that I was offered a copy of HIPPA regulations and that I understand my right to confidential services as outlined, including the limitations. I also understand that I may wave my rights and authorize the exchange of information, when necessary and appropriate, and that I must do so in writing.

_____

Client Signature Date

_____

Signature of Parent/Guardian of Minor Child Date

_

_____

Witness Date

MIND POTENTIAL NORTHWEST RELEASE OF INFORMATION

There are times when it is helpful to exchange information with individuals and/or organizations regarding the services you are receiving. The information shared is on a "need to know basis" only and by signing this form, you are giving permission for these individuals and/or organizations to share information about your situation. If there is no need for this ROI, please write N/A in each of the fields.

Client Name: _____DOB: _____

I authorize: Darla Meulemans of Mind Potential Northwest, LLC
5200 S Macadam Ave, Suite 160
Portland, OR 97239
Telephone: (503) 757-9557 Fax: (503)653-9356

and:

_____

_____

_____

_____

To exchange for the purpose of:

_____

The permission is good for one year or until: _____

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. Any disclosures are bound by Federal Regulations (42 CFR Part 2 & HIPAA) that govern confidentiality in alcohol and drug abuse and mental health records. I approve release of this information and I fully understand what this agreement means. I am signing on my own and have not been pressured to do so.

_____

Client Signature / Parent or Guardian Signature Date

_____

Signature of Witness Date

PROHIBITION OF RE-DISCLOSURE

CLIENT RECORDS ARE PROTECTED BY FEDERAL LAW WHICH PROHIBITS YOU FROM MAKING FUTURE DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.

MIND POTENTIAL NORTHWEST FEE AGREEMENT

Client Name: _____ Date of Birth: _____

_____

Name of Party Responsible for Payment Relationship to Client

_____

Billing Address

Mind Potential Northwest, LLC offers personal development consultation, professional mentoring and neurofeedback services to individuals and businesses. The fees for these services will depend on the actual service provided and the duration of the session, and are based on cash, check, Venmo, CashApp or Zelle payment. **A 4% service fee will be charged for all credit card transactions**. All fees for services are due at the time of services unless other arrangements have been made. **I DO NOT DO ANY INSURANCE BILLING, INCLUDING MEDICARE OR MEDICAID.**

□ **This agreement is valid for service provided by Darla Meulemans or designee.**

□ **There is a $30 fee for any returned checks and a $30 fee for any record requests.**

Neurofeedback Evaluation (Includes Part I via Zoom + Initial Office Visit)	**$425.00**
Initial Distance Neurofeedback Evaluation (Includes Part I Zoom Interview & Part II Zoom Consultation on sensor placement, equipment hookup, QIK Test & initial brain training)	**$495.00**
45-minute Awake State Neurofeedback **Distance / Combined Sync / AT** **75 Minute Combined Session** **90 Minute Combined Session**	**$175.00** **$195.00** **$225.00** **$275.00**
Mentoring / Consultation (billed in 15, 30, 45, 60, 75 & 90-minute intervals)	**$220.00/hr**

I, _____(Client) agree to be financially responsible for payment for all services or returned check/bank fees, due to Mind Potential Northwest, LLC. If a third party is being billed for services and does not pay, I agree to make payments, as specified, until the final balance is paid in full.

I understand that services may be discontinued if payment is not received or until other financial arrangements can be made. I further understand that Mind Potential Northwest, LLC has the right to assign collections to an outside agency in the event I fail to pay any outstanding balance for services.

_____

Client Signature Date

_____

Parent or Guardian Signature Date

mind potential northwest, llc

personal & professional development
performance training & neurotherapy

CLIENT INFORMATION SHEET

Name:	Age:	DOB:

Address:

Phone:

E-mail:

Employer:	Occupation:

Referred by:

Spouse / Partner or Parent /Guardian:

Employer:	Occupation:

Other Family Member's Names	Gender	Age

Emergency Contact* (By listing this person you give permission to contact them in the event of an emergency.

Name:	Relationship to Client:	Phone:

mind potential northwest, llc

personal & professional development
performance training & neurotherapy

Reason(s) for seeking services: (Mark an X next to ALL that apply)

	Stress		Anxiety		Depression
	Sleep Problems		Addiction		Poor Concentration
	Health Concerns		Compulsive Behaviors		Mood Swings
	Relationship		Nutrition / Food Issues		Anger
	Performance		Grief / Loss		Cognitive Problems
	Obsessive Worry		Hyperactivity		Sexuality
	Fears / Phobias		Self-Esteem		Job / Career
	Other:				

Specific desired goals or concerns for which services are desired:

How long have you been experiencing the above concerns and what were the circumstances when you first realized you were having this experience?

On a scale of 0-10 with 0 = "Not At All" and 10 = "Extremely", how committed are you to getting to the heart of the matter so you can be free from the unpleasant experiences?

What behaviors and habits do you currently engage in that you believe support your well-being?

What behaviors and habits do you currently engage in that you believe inhibit your experience of health and mental well-being?

List all the people you know who will sincerely and consistently support you with this process.

mind potential northwest, llc

personal & professional development
performance training & neurotherapy

SYMPTOMS TRACKING FORM

Name: _____ Date: _____

Reported by: _____

Relationship to Client: _____

Mark the Box with a "0-10" rating for current level of disturbance / distress for each symptom.
Mark an "H" next to any symptom you have experienced in your past (historically).

Category 1: Sleep			
Bruxism (Jaw Clenching / Teeth Grinding)		Difficulty Falling Asleep	
Difficulty Maintaining Sleep		Difficulty Waking	
Disregulated Sleep Cycle		Narcolepsy	
Night Sweats		Night Terrors	
Nightmares or Vivid Dreams		Nocturnal Enuresis (bedwetting)	
Periodic Leg Movements		Restless Leg	
Restless Sleep		Sleep Apnea	
Sleep Walking		Snoring	
Talking During Sleep			
Comments:			
Category 2: Attention & Learning			
Difficulty Completing Tasks		Difficulty Following Directions	
Difficulty Making Decisions		Difficulty Organizing Personal Time & Space	
Difficulty Remembering Names		Difficulty Shifting Attention	
Difficulty Understanding Conversations		Distractability	
Lack of Alertness		Lacking Common Sense	
Messy Handwriting		Not Listening	
Poor Concentration		Poor Drawing Ability	
Poor Math		Poor Short Term Memory	
Poor Sustained Attention		Poor Verbal Expression	
Poor Vocabulary		Poor Word Finding	
Reading Difficulty		Slow Thinking	
Unmotivated		Dimentia / Early Altzeimer's	
Comments:			
Category 3: Sensory			
Auditory Hypersensitivity		Chemical Sensitivities	
Motion Sickness		Poor Body Awareness	
Somatosensory Deficits		Tactile Hypersensitivity	
Tinnitus		Vertigo	
Visual Deficits		Visual Hypersensitivity	

Comments:			
Category 4: Behavioral			
Addictive Behaviors		Aggressive Behaviors	
Anorexia		Autistic Stimming	
Binging and Purging		Class Clown	
Compulsive Behaviors		Compulsive Eating	
Crying		Excessive Talking	
Hyperactivity		Impulsivity	
Inflexibility		Lack of Appetite Awareness	
Lack of Sense of Humor		Lack of Social Interest	
Manipulative Behaviors		Motor or Vocal Tics	
Nail Biting		Oppositional or Defiant Behavior	
Poor Eye Contact		Poor Grooming	
Poor Social or Emotional Reciprocity		Poor Speech Articulation	
Rages		Self-Injurious Behavior	
Stuttering		Fecal Smearing	
Comments:			
Category 5: Emotional			
Agitation		Anger	
Anxiety		Depression	
Difficult to Soothe		Dissociative Episodes	
Easily Embarrassed		Emotional Reactivity	
Fears		Feelings of Unreality	
Trauma History (Physical, Emotional, Sexual)		Impatience	
Flashbacks of Trauma		Lack of Emotional Awareness	
Irritability		Lack of Social Awareness	
Lack of Pleasure		Mania	
Low Self-Esteem		Obsessive Negative Thoughts	
Mood Swings		Panic Attacks	
Obsessive Worries		Suicidal Thoughts	
Paranoia			
Comments:			
Category 6: Physical			
Allergies		Asthma	
Chronic Constipation		Clumsiness	
Difficulty walking or moving		Difficulty Working	
Effort Fatigue		Encopresis (loss of bowel control)	
Fatigue		Heart Palpitations	
High Blood Pressure		Hot Flashes	
Immune Deficiency		Irritable Bowel	
Low Muscle Tone		Muscle Tension	
Muscle Twitches		Muscle Weakness	
Nausea		PMS Symptoms	
Poor Balance		Poor Fine Motor Coordination	
Poor Gross motor coordination		Reflux	
Rigidity		Seizures	
Skin Rashes		Spasticity	
Stress Incontinence		Sugar Craving or Reactivity	
Sweating		Tachicardia	
Tremor		Urge Incontinence	

Traumatic Brain Injury / Head Trauma			
Comments:			
Category 7: Pain			
Abdominal Pain		Chronic Aching Pain	
Chronic Nerve Pain		Fibromyalgia Pain	
Jaw Pain		Joint Pain	
Migraine Headaches		Muscle Pain	
Muscle Tension Headaches		Sciatica	
Sinus Headaches		Stomach Aches	
Injury Specific Pain			
Comments:			

LIFESTYLE & HEALTH HISTORY REPORT

Client Name:	DOB:

For Youth Clients:

Person Completing Form:	Relationship to Client:

Date of Last Medical Exam:	Physician's Name:

Outcome / Treatment Recommendations:

Has you ever lost consciousness, fainted, or had a head injury? Mark with X

	Yes		No

If yes, please describe:

Previous medical / neurological interventions (pain / other injections, hospitalizations, surgeries, physical or other therapy, brain scan, X-rays, bio / neurofeedback, other):

Date	Type of Intervention	Outcome

Previous / current mental health or psychiatric history:

Diagnosis / Symptoms	When?	Professional Care?

Have you ever been hospitalized for psychiatric reasons? If yes, when and what were the circumstances:

Current Medications: **(Please Attach an additional sheet, if necessary)**

Name	Dosage	Symptom Being Treated	Effectiveness (1-10)	Side Effects (1-10)

Use of non-prescription medication (aspirin, Tylenol, Advil, decongestants, sleep medication, nasal sprays, inhalers, vitamins, supplements):

Past / Current use of stimulants and social drugs (please indicate when (past or present), the # of times used per week, month, or year)

Alcohol		Cigarettes	
Opiates		Stimulants	
Hallucinogens		Ecstasy / Synthetics	
Marijuana		Coricidin / Dextromethorphan	
Coffee/Tea/Caffeine		Other	

What words would you use to describe your typical daily mood – morning, noon, and night?

Do you do anything specifically that helps you relax? (meditation, breathing, yoga, reading, listening to music)

Nutritional Habits (Describe your typical daily eating habits):

Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Snack	

How often do you eat out, including take-out?

How often do you skip meals?

What foods do you most often choose to cope with stress? (Sugar, Caffeine, Salt, Chocolate) and how often?

Sleep Habits

What time do you typically go to bed?	
How long does it take you to fall to sleep?	
How many times do you wake up in the night?	
Do you feel rested upon rising?	

What wakes you up? Noise? Bathroom? Thoughts? Dreams? Temperature (too hot or too cold?)	
Do you snore or have signs of sleep apnea?	
What time do you wake up in the morning during the week?	
What time do you wake up on weekends or days off?	
Is it difficult to get out of bed and get your day moving?	
How many hours / day do you watch television or movies, play video games, or work on the computer?	

Any other issues or concerns you would like to make me aware of?

Family History

Symptom	Yes	No	Relationship
Asthma			
AutoImmune Disorders			
Thyroid Disorder			
Migraine			
Sleep Problems			
Depression			
Bi-Polar			
Anxiety			
Phobias			
Panic Attacks			

Motor / Vocal Tics			
Seizures			
Eating Disorders			
Addiction			
Obsessive Compulsive Symptoms			
Speech Problems			
Attention Problems			
Hyperactivity			
Learning Problems			
Conduct / Criminal Problems			
Autism			
Schizophrenia			

Lifeline / Timeline

Client Name:	Date of Birth:
Completed by:	

NOTE: To be completed by Parents/Guardian of youth clients or clients with developmental differences.

Please list significant events, people, relationships, experiences, and memories from each of the following stages of development:

Prenatal - Birth: (Indicate the physical and emotional state of health of the biological mother during pregnancy, and any birth trauma (C-section, loss of Oxygen, long labor, natural childbirth, low Apgar scores, etc.)

0-5 years: (Indicate if developmental milestones were met at appropriate ages – crawling, walking, talking, toilet training, etc. Also indicate sleep issues, social concerns, etc.)

6-9 years: (Indicate how transition to schooling was, socializing, academic performance, etc.)

10-13 years: (Indicate peer relations, academics, physical development, age of first menses (if client is female), etc.)

14-17 years:

18-21 years:

22-25 years:

26-30 years:

31-35 years:

36-40 years:

40's: (For women, indicate the onset of menopause – emotional & physical symptoms)

50's:

60's;

70's & Onward;