LENS Neurofeedback Preliminary Questionnaire

Please answer the questions below. The LENS provider will review your responses before scheduling.

Name (required)

Date of birth (required)

Phone (required)

Email (required)

1. What are you hoping LENS neurofeedback may help you with?

2. Have you recently been hospitalized, treated in a psychiatric emergency department, or received psychiatric crisis care?

- ○ No
- ○ Yes

If yes, approximately when?

3. Are you currently experiencing a significant worsening of your psychiatric or emotional symptoms?

- ○ No
- ○ Yes
- ○ Unsure

4. Are you currently in a psychiatric or medical crisis, or having thoughts of harming yourself or someone else?

- ○ No
- ○ Yes

If yes: Do not wait for a response to this form. Follow the clinic's emergency instructions or seek emergency care.

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5. Have you ever had a seizure or been diagnosed with epilepsy?

- ○ No
- ○ Yes
- ○ Unsure

6. Have you ever experienced any of the following?

Tics	○ No	○ Yes
Migraines	○ No	○ Yes
Headaches	○ No	○ Yes
Cluster headaches	○ No	○ Yes
Stuttering	○ No	○ Yes
Tourette syndrome	○ No	○ Yes
Explosiveness	○ No	○ Yes

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Please answer the questions below. The LENS provider will review your responses before scheduling.

7. Have you received neurofeedback before?

- ○ No
- ○ Yes

If yes, did you have a difficult or concerning response?

- ○ No
- ○ Yes
- ○ Unsure

If yes, briefly describe what happened.

8. Please list your current medications.

Medication name and dose, if known

9. Have there been any recent changes in your medications?

- ○ No
- ○ Yes

10. Is there anything else you think the LENS provider should know before speaking with you?

Acknowledgment

I confirm that the information I have provided in this questionnaire is accurate and complete to the best of my knowledge. I understand that this information is used to help determine whether LENS neurofeedback can be appropriately scheduled and that I should inform the provider if any of this information changes.

☐ **I agree** **Name** **Date**