Be. Here. Now.

The Mindfulness Clinic

Informed Consent & Release Form For EEG Recording and Biofeedback Training

I authorize The Mindfulness Clinic to provide biofeedback and record my EEG. Neurofeedback is a form of biofeedback (EEG or brain biofeedback) that offers auditory and/or visual information to individuals about their brain activity. Many conditions appear to be associated with types of brain wave patterns or activity.

Sensors on the scalp: Recording an EEG or providing Neurofeedback requires placement of sensors on the scalp for the purpose of measuring the EEG to either provide visual or auditory feedback from the digital signal or the recording EEG electrical activity in a digital form. It is generally accepted that the act of recording the EEG does not affect the individual.

Input from the client is important: It is important for the client to provide feedback about any perceived changes in symptoms or other changes during or after Neurofeedback training. Changes noted 1 to 5 days after the last training are particularly important. The client should note changes and provide that information at their next session.

Review progress periodically: The client may ask for a formal review of progress with the Biofeedback Clinician at anytime but reassessments are generally scheduled after 20 sessions. Discussion is invited anytime.

Effect on medications: It is typical that changes an individual may achieve in training with Neurofeedback may affect an individual's response to medications. Please discuss changes you perceive in response to medication to your Biofeedback Clinician. Medications should not be stopped or altered without consulting your physician or psychiatrist. Should new symptoms develop or if symptoms change, it is the client's responsibility to inform his/her healthcare providers, including the Biofeedback Clinician.

Progress varies by individual: Although research and clinicians worldwide have reported progress with a high percentage of clients, no representation is made that an individual client will improve from biofeedback. The amount of time it takes for progress to be made varies. Although the changes made are long-lasting, some clients report that improvements fade at some point after training ends. These individuals typically benefit from booster trainings.

By signing below, you acknowledge that you have read and understand this document and are ready to begin biofeedback training.

PRINT FULL NAME:_____

SIGNATURE:_____DATE:_____

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Today's Date: _____ **Contact Number:** _____ ☐ Male ☐ Female

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

Address: _____ **Email:** _____
Number and Street City State Zip

Main Contact(s): *(If not the Client, other contacts)*

Name	Relationship	Cell Phone	Email Address

Messages:

If we call you, may we leave a message with someone else?	☐ Yes	☐ No
May we leave a voicemail message?	☐ Yes	☐ No
Can we text or email you, if needed?	☐ Yes	☐ No

Goals for training or primary problem(s) you'd like to improve: _____

Other providers helping with these issues _____

How did you hear about us? _____

List all prescribed medications:

Medication(s)	How long on them?	Comments	Medication(s)	How long on them?	Comments

List all supplements/OTC medications:

Supplement(s)/OTC	How long on them?	Comments	Supplement(s)/OTC	How long on them?	Comments

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What brings you here today?

- ☐ Anxiety
- ☐ Sleep
- ☐ Depression
- ☐ Processing or cognitive difficulties
- ☐ Attention issues
- ☐ Pain/headaches
- ☐ Other: _____

Handedness: ☐ Right ☐ Left ☐ Ambidextrous

Have you ever:

☐ had a concussion? ☐ been hit very hard in the head?
☐ lost consciousness? ☐ had a head injury

Explain: _____

Sleep Patterns:

Typical times you go to sleep: _____

Typical times you wake: _____

Sleep through the night?	☐ Yes	☐ No	☐ Sometimes	
Fall asleep easily?	☐ Yes	☐ No	☐ Sometimes	
How long to fall asleep? (minutes/hours)	_____			
Wake up easily?	☐ Yes	☐ No	☐ Sometimes	
Wake feeling rested?	☐ Yes	☐ No	☐ Sometimes	
Good sleep per week:	☐ 1-2 nights	☐ 3-4 nights	☐ 5-6 nights	☐ Almost always

Other comments about your sleep _____

					Comments
Are you sensitive to caffeine? *(Coffee, Tea, Chocolate, Cola)*	☐ Yes	☐ No			
Does caffeine make you...	☐ Alert/awake	☐ Jittery/ wired/hyper	☐ Relaxed	☐ No effect	
Do you use alcohol?	☐ Never	☐ Daily	☐ Monthly	☐ Less	
Does alcohol make you...	☐ Tired	☐ Relaxed	☐ Better	☐ Worse	
Do you have a history of using recreational drugs?			☐ Yes	☐ No	

If yes, explain: _____

Do you have any psychiatric or mental health diagnosis? ☐ Yes ☐ No

If yes, any related hospitalizations?

Have you had any suicidal thoughts or thoughts of self-harm?	☐ Yes	☐ No
Plans?	☐ Yes	☐ No
Attempts?	☐ Yes	☐ No

If yes, explain: _____

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Any Important family history issues that may relate to current challenges/symptoms (divorce, disruptions in family, major job challenges, loss of family or friend, etc.)

_____

_____

History of help utilized:

☐ Counseling or Behavioral Therapy
☐ Exercise or Yoga
☐ Medications
☐ Acupuncture/massage
☐ Special diets or nutrition

Comments: _____

How long have you been dealing with your primary issues? _____

Are these issues that occur every day all day, or intermittently? How often do they occur? _____

_____

Has anything helped these issues in the past? _____

_____

Does it hinder your ability to engage in activities or work or be with family or friends? _____

_____

PHYSICAL: ☐ Headaches ☐ Stomach issues ☐ Constipation ☐ Other _____

Can you describe physical symptoms – for example: hands sweating, chest tightening, tight stomach, hard to breathe, etc. _____

_____

Any history of trauma/being bullied/abuse: _____

_____

Do you think you have problems keeping up/being sharp/making decisions? _____

_____

☐ Healthy self-esteem? ☐ Excessively obsessive or worried? ☐ Easily overwhelmed?

How would you describe yourself? _____

_____

Is there excessive sensitivity to light/sound/noise? _____

This is a "Gut-Brain question": Estimate how many rounds of antibiotics you've had since you were born: _____

_____

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Any Important family history issues related to child (divorce, disruptions in family, loss of family, adoption, foster, etc.)

_____

_____

History of help utilized:

☐ Counseling or Behavioral Therapy Comments: _____

☐ Occupational Therapy _____

☐ Tutoring _____

☐ Speech _____

☐ Medications _____

☐ Special diets or nutrition _____

_____

Any IEP or 504 plan or accommodations? _____

Greatest Strengths: _____

Any developmental or other early relevant history: _____

_____

PHYSICAL: ☐ Headaches ☐ Stomach issues ☐ Constipation ☐ Other _____

Does the child GET ALONG well with...?

Parents/Step-Parent/Guardian	☐ Yes	☐ No	☐ Sometimes	Comments: _____
Siblings	☐ Yes	☐ No	☐ Sometimes	_____
Friends and Peers	☐ Yes	☐ No	☐ Sometimes	_____
Teachers	☐ Yes	☐ No	☐ Sometimes	_____

_____

ACADEMICS: Is the child doing well academically? ☐ Yes ☐ No

Is the child behind grade level in ☐ Reading ☐ Math ☐ Spelling ☐ Other Subjects

Are there other subjects the child struggles more with than others? _____

_____

Does your child avoid activities? ☐ Yes ☐ No If so, why? _____

Is there difficulty shifting from one activity to another (transitioning)? ☐ Yes ☐ No

How would you describe this child? _____

_____

Is there healthy self-esteem? ☐ Yes ☐ No Is the child fearful? ☐ Yes ☐ No

Is there excessive sensitivity to light/sound/noise? ☐ Yes ☐ No

The Mindfulness Clinic

Client Intake Checklist

Full Name:_____

Date of Birth:_____

Have you experienced or do you currently experience SEIZURES? (yes/no)

Have you experienced or do you currently experience MIGRAINES? (yes/no)

Have you experienced or do you currently experience DISASSOCIATION (ex: disconnecting from one's thoughts, feelings, or memories or sense of identity) ? (yes/no)

Have you experienced a TRAUMATIC BRAIN INJURY? (yes/no)

Do you have a PACEMAKER? (yes/no)

Scheduling Appointments:

In the initial stages of training, it is often necessary to have neurofeedback sessions three times per week. We encourage you to schedule these appointments in advance so that times most convenient to you can be reserved. If it is necessary to cancel an appointment, please make every attempt to reschedule the appointment within the same week so that the optimum session frequency is maintained.

Cancellation Policy:

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting a much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

- Any no shows/failure to reschedule within 1 hour of your session will be charged a full session fee. ($75)
- 10 Minutes late with result in forfeiting your session.

I acknowledge my active participation in the formulation of treatment arrangements. I understand its content and agree to abide by these stipulations unless mutually modified at a subsequent time.

PRINT FULL NAME:_____

SIGNATURE:_____DATE:_____

The Mindfulness Clinic

Client Intake Checklist

Training, Planning, and Assessments:
A comprehensive training plan is developed based on the client's goals, symptoms, and results of the assessments. A typical neurofeedback training program takes from 20-60 sessions with 40 being the average. Each person is unique and may need more or less. In most cases, a change will be noticeable by the 15th session; however there are people who need more sessions before positive symptom relief can be noticed. The current understanding among neurofeedback providers is that it takes a minimum of 20 sessions for a client to maintain the gains that they have made. Progress will be evaluated around the 20th session and recommendations for further training will be made at that time.

Limits of Confidentiality
Your confidentiality will be protected and respected by our staff. We are legally mandated to break confidentiality in the following situations:

a. If the client may be in immediate danger to self or others.
b. If the client is endangering a population that cannot protect itself, such as the case of child or elder abuse.
c. To share diagnosis information as necessary to obtain payment for services. D. As required by federal or state laws.

Other than the noted exceptions, if there are reasons to disclose protected confidential information, you will be provided with a Release of Information form.

I acknowledge my active participation in the formulation of treatment arrangements. I understand its content and agree to abide by these stipulations unless mutually modified at a subsequent time.

PRINT FULL NAME:_____

SIGNATURE:_____DATE:_____

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