familyservices WINDSOR-ESSEX COUNSELLING & ADVOCACY CENTRE

INITIAL NEUROFEEDBACK QUALIFYING QUESTIONNAIRE

Name	
DOB	
Address	
Phone	
Email	

Date of PTSD Diagnosis:	
Diagnosing Physician/Psychologist/Psychiatrist:	
Reason for diagnosis [include date(s) & detail(s) of traumatic event(s) experienced]:	

CRITERION TO BE MET (please check):	**YES**	**NO**
Are you able to commit to completing up to 25 Neurofeedback (NFB) sessions in total? (1 to 2 sessions a week)	☐	☐
Are you able to abstain from consuming alcohol during NFB treatment?	☐	☐
Are you able to abstain from non-prescription drugs (including but not limited to cannabis, cocaine, methamphetamine, heroin) during NFB treatment?	☐	☐
Are you able to abstain from caffeine, alcohol, non-prescribed drugs 24 hours prior to your brain mapping & brain training sessions?	☐	☐
Do you agree to comply with all prescribed psychotropic & other health related medications?	☐	☐
Do you agree to keep your prescribing physician aware of your progress?	☐	☐
Are you able to fund all treatment sessions?	☐	☐

AM I A GOOD CANDIDATE FOR NEUROFEEDBACK?										
On a scale of 1-10 please rate your:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
• Intention towards progress goals										
• Positive attitude										
• Commitment to attend regularly										

Please email completed form to neurofeedback@fswe.ca

If you are a qualifying candidate, you will be contacted to schedule your initial assessment session with your assigned Neurofeedback therapist. Thank you.