Dear Patient,

We would like to welcome you and thank you for making a neurofeedback appointment with us at Peter Bower M.D. and Associates. We look forward to seeing you for your upcoming visit and to help prepare we ask that you complete a few forms prior to coming in. In this packet you will find an **Intake Form** and **Informed Consent Form, please print and complete these and bring them with you when you come in for your appointment**. Also included is a brief explanation of neurofeedback as well as your **Brain Map Prep Instructions**, please read all these forms carefully and complete the tasks as instructed prior to your appointment.

In addition to the paper forms, there are several assessments you will need to complete online. The website to access these is www.my-newmind.com you will need to contact us at the phone number or email address below to get your login information. Once logged in you must complete the **Physiology, ISI, and CEC** assessments as well as the **Cognitive Performance Testing**. Please complete all of these prior to your initial appointment, all of these will generally take around one hour to complete so leave yourself enough time to finish them. You may come early for your appointment and fill out these forms in our office if you prefer, it is helpful to let us know in advance if this is what you would like to do.

For any further questions you may have, please do not hesitate to call myself or Rachel at (434)978-3609 or email at neurobio@soundmedicine.com. We are happy to assist you however we can and we look forward to seeing you for your upcoming appointment.

Thank you,

Diana Bower R.N., F.N.P.

What Is Neurofeedback?

Neurofeedback literally means "brain" and "input", where the brain is monitored and input is given instantly. Neurofeedback specifically monitors brainwaves, looks for irregularities, and produces a signal that is designed to correct the irregularity and guide the brainwave back into a healthy pattern. With repetition of this process over time, the brain will learn to stay in healthy ranges without the aid of the computer. The result is an improvement in brain regulation, which in turn can reduce or eliminate most neurological symptoms.

What Type Of Input Is Used?

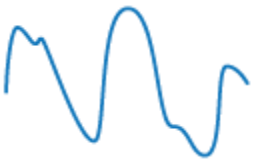
The signal source varies based on the system used, but it usually involves audio or video of the patient's choosing. The process is so easy; a patient can actually get better just by listening to their favorite music or watching their favorite videos. **The process is non-invasive, requires no drugs and is pain free.**

Who Can Benefit?

Neurofeedback can work on anyone, no matter the age. All that is required is the ability to focus on the audio or video stimulation. Any neurological condition that involves irregular brainwaves can be targeted and improved with neurofeedback. These conditions include attention-deficit disorder, addiction, anxiety, autism, brain injury, depression, fibromyalgia, insomnia, migraines, obsessive compulsive disorder, stress, stroke and more!

What Are Brainwaves? How Do They Affect Me?

Neurofeedback targets the four primary brainwaves (Delta, Theta, Alpha, and Beta). Each of these brainwaves is responsible for regulating the active and subconscious aspects of your body. Take a look at the following diagram:

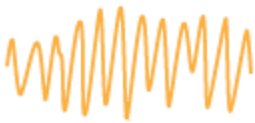


Delta Brainwave

Sleepy, Dreaming

Theta Brainwave

Drowsy, Meditative



Alpha Brainwave

Relaxed, Reflective

Beta Brainwave

Alert, Working

Delta brainwaves are associated with deep, dreamless sleep and regeneration. Delta brainwaves occur when you are asleep and are responsible for healing the body.

Theta brainwaves are associated with light sleep or extreme relaxation. When your subconscious takes over you start producing Theta brainwaves.

Alpha brainwaves occur when you are awake but relaxed and not processing much information. When you first get up and right before you fall asleep, you are generating Alpha waves, as well as when you close your eyes to rest.

Beta brainwaves are associated with the mental state most people are in during the day and most of their waking lives. When you are alert and focused, you are producing Beta brainwaves.

While each of these brainwaves is responsive for different body functions, they all are equally important to your health and well-being. Researchers have known for decades the correlation between Irregular brainwaves and common neurological conditions. Neurofeedback is the first field to directly target these irregular brainwaves and restore them to normal ranges.

Decades of Research

Over 1,000 studies have been published in relation to neurofeedback and biofeedback. The early animal research, which has been validated in many peer reviewed journals since the 1970's, showed that brainwaves can be changed through operant conditioning, and that seizures are reduced with EEG training. These studies were originally done in the 1960's using cats with no chance of placebo effects. Since the 1970's, research has been verified in human studies, and through decades of additional research on humans of all ages the basis for neurofeedback has become extremely solid. You can browse many research articles for specific conditions by visiting http://www.clearmindcenter.com/research.

Brain Map Prep Instructions

To begin your neurofeedback treatment, our first session with you will involve a QEEG brain map to identify irregular brainwave patterns. To do this we will use a cap that transmits the electrical impulses in your brain to our software which will generate a detailed report identifying problem areas and how we will address them. In order to get a clear signal of these brainwaves we need you to prepare in advance so that your brain is well rested and clear.

1. Avoid any over-the-counter medications for 3-4 days prior to your brain mapping. This includes any supplements and vitamins you currently take.

2. If you are sick, even if it is a minor cold, we ask that you reschedule your appointment. Illness affects the brain and can inhibit a clean reading of your brainwaves.

3. If you are taking stimulant medications (such as medications for ADHD, etc.) these should not be taken 48 hours prior to your brain mapping. You should **first ask your physician if this is possible** and if 48 hours is not, avoiding them for 24 hours or 12 hours is preferable if you are able to do so. The clearest brain maps are recorded with as little medication as possible.

4. Do not drink highly caffeinated beverages (coffee, tea, Red Bull, etc.) for at least 15 hours prior to your appointment. If you habitually consume large amounts of caffeine and avoiding it altogether will induce headaches or fogginess you may just lower your intake for the 15 hours before your mapping.

5. The night before your brain map please wash your hair 3 times with a pH neutral, cleansing/clarifying shampoo. Neutrogena non-residue shampoo is what we recommend using. Do not use any other hair products after washing, do not wash your hair the morning of your appointment, and make sure that your hair is completely dry before coming in.

6. Get a good night's sleep, at least 6 hours. Your brain requires sleep to function clearly.

7. The morning of your appointment eat a high protein breakfast and drink plenty of water.

In order to transmit a good signal we use a water soluble electro-gel that will be put in your hair, we have facilities for you to rinse your hair after your session if you like, be aware that you may wish to leave time for that after your appointment. Your brain mapping session will be most helpful to us and more importantly to you if you follow these instructions closely. Thank you!

Informed Consent for NeuroIntegration Therapy

This practice offers NeuroIntegration Therapy, also known as EEG (brain wave) biofeedback (neurofeedback) training, to clients requesting such services. The training is offered to children and adults, either self-referred or identified by parents, physicians, teachers or other referral sources as having conditions shown to be responsive to this training. These conditions are generally thought to be those that appear to be associated with irregular brain activity where there is also clinical and research evidence to suggest neurofeedback training as a viable treatment approach.

Our staff has education, training and experience in neurofeedback and in EEG technology. We recommend the training based on our observations of improvement in clients with similar conditions. Scientific investigation is ongoing to determine the mechanism by which these improvements are achieved and therefore EEG neurofeedback is still considered by many to be an experimental treatment. We use standard methods to determine the proper training program and to measure progress during and after training. Neurofeedback is, however considered an experimental approach and therefore we need client or parental informed consent for this training.

We do not claim that you or your child will improve from the training. However, test results indicate that more than 80% of clients improve on at least one test scale, and more than half improve on three out of four scales. A few clients who seem to get better at first may find that the improvement does not last after the training ends. Such clients may benefit from regular follow-up sessions. Some individuals may not experience any effects at all from the training. Our staff is always happy to discuss client progress. Other methods may also be effective for you or your child. We will be happy to provide information about such services at your request. Individual and/or family counseling may help you and/or your child integrate the gains from neurofeedback into everyday family, social, school and work environments.

Neurofeedback training has been the subject of more than 30 years of research and clinical study. The training appears to be harmless as far as is known at present and no injuries have been reported, or documented in a review of research literature. Neurofeedback is not a treatment; it is a training process. The instruments are merely measuring devices similar to a thermometer. Sensors are placed on the surface of the head and your child is given information about what is being measured. Nevertheless, beyond this, we do not make any representation concerning the safety or effectiveness of the training. Clients should continue other ongoing therapies until otherwise advised by a physician.

When you sign this form, you are indicating that you understand the information that it contains.

When you agree to participate in this program, you or your child are not obligated to complete the training if for any reason you believe it is not in your or your child's best interest. This means you may discontinue participation at any time. Training and test results will be available to clients and/or parents.
If you, or anyone else who will use this machine, are subject to any form of seizures, epilepsy or visual photosensitivity please notify us prior to starting Neurofeedback training.

Yes, I understand and agree to the terms of this document. Yes, you may administer standard tests

Name of Client: _____ **DOB**: _____ **Phone #:** _____

Client Signature: _____ **Date:** _____

Parent/Guardian Name (if client is a minor): _____ **Phone #:** _____

Parent/Guardian Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

NeuroIntegration Intake Form

PERSONAL INFORMATION

Name _____ Date of birth: _____/_____/_____
Address _____ Age: _____ years
City _____ State _____ Zip _____ Gender: M F
Email address _____
Home Phone _____ Cell Phone _____
Work Phone _____ Fax _____
Occupation _____

Tell us more about your needs and desires regarding brain health.
How can we help? What are you hoping to address or achieve through our NeuroIntegration Program?

HEALTH INFORMATION

1. OVERALL HEALTH
On a scale of 1-10, how would you rate your current health? 1 2 3 4 5 6 7 8 9 10
(1 being the worst, 5 being average, 10 being the best)

2. SLEEP
Rate the quality of sleep you usually get in the past month. 1 2 3 4 5 6 7 8 9 10
At what time do you go to bed? _____am/pm
At what time do you rise in the morning? _____am/pm

Are you able to sleep through the night? YES NO
If NO, please describe:

Are you able to fall asleep easily most nights? YES NO
If NO, please describe:

Do you wake refreshed? YES NO
If YES, please describe any exceptions:

3. HEAD or NECK INJURY
Have you ever injured your head or neck? YES NO

Ever had a concussion? YES NO

If yes, have you suffered more than one concussion? YES NO

Have you ever been in an auto, motorcycle or bicycle accident? YES NO

Have you ever had a traumatic brain injury? YES NO

Are you currently receiving care for this/these injuries? YES NO

Please describe your head or neck injuries using the reverse side of this page, thinking back over the years. Please consider the childhood and teen years, as well as adulthood, including home life, sports, accidents, slips/falls, etc.

4. CHRONIC HEALTH PROBLEMS?
Please list any chronic medical problems or brain health issues you have on the back side of this form.

5. HORMONES
Are you concerned that hormonal imbalances that may be contributing to your condition? YES NO

6. MOODS & EMOTIONS
How would you describe your general emotional state? (A brief sentence or short phrase of 3-4 words is fine.)

7. MEDICATIONS, SUPPLEMENTS & VITAMINS
If you haven't previously listed these on our intake form, please provide a list here including name, dose, frequency and for what symptom you are taking each. Feel free to use the other side.
Medications Nutrition Supplements/Vitamins

ANY KNOWN MEDICATION ALLERGIES? YES NO
Please list any medication allergies you may have:

8. SUBSTANCES
Do you currently use psychoactive drugs, medications or alcohol to pick yourself up or calm yourself down? YES NO
Have you ever used psychoactive drugs, medications or alcohol in the past to pick yourself up or calm yourself? YES NO
Are you currently a smoker? YES NO
Do you consider your current use of tobacco, alcohol or street drugs a problem? YES NO
If yes on any of these substances, circle those currently taking.

Do you feel depressed or anxious at the present time? Depressed Anxious Neither
Have you suffered from depression or anxiety in the past?
Circle condition if yes. YES NO

9. ATTENTION & LEARNING
Any history of learning difficulties? YES NO
Any history of memory problems? YES NO

Any history of ADD/ADHD? YES NO
In childhood? Adulthood? (please circle)

10. OTHER CONDITIONS
Any history of other psychiatric conditions in yourself, such as schizophrenia, bi-polar disorder, psychosis? YES NO
Any history of other psychiatric conditions in family members, such as Schizophrenia, bi-polar, psychosis? YES NO

11. COUNSELING & PSYCHOTHERAPY
Are you currently working with a psychiatrist, therapist, counselor or clergy in matters regarding your mental health? YES NO
If yes, please list name/names _____

12. SEIZURES or LIGHT SENSITIVITY?
Are you, or have you ever been, sensitive to lights or strobe lights, had or been diagnosed with migraines or epileptic seizures? YES NO

13. Is there anything that you would like to add?

Parent or Guardian of Minor, please complete this section
Parent/Guardian Name _____

Address _____ City _____ State _____ Zip _____

Do you live with the patient? Y N Phone _____