

Echo Rock Therapy Center LENS Intake Form

Name: _____ Age: _____ Today's Date: _____

Full Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____

How did you find out about us? _____

Primary Care Doctor: _____ Phone: _____

Additional Care: _____ Phone: _____

Additional Care: _____ Phone: _____

Most Prominent Problems

Date of onset or accident

1. _____
2. _____
3. _____

How were you before these problems occurred? What job or skills have you lost?

Previous symptoms throughout your entire life?

Current medications and drugs, reasons for taking them, and their effects?

Basis for Incomplete Problem Resolution:

Past? Present?

- | | | |
|---|-------|-------|
| 1. Unpredictable things had a big effect on me. | _____ | _____ |
| 2. Situations were embarrassing for me. | _____ | _____ |
| 3. Friends and/or family had a hard time being around me. | _____ | _____ |
| 4. I was troubled by emotions/feelings. | _____ | _____ |
| 5. I had migraines/tics/seizures/explosive episodes | _____ | _____ |
| 6. Other kids teased me about _____ | _____ | _____ |

How much time and money have you spent on your primary problem?

How will you know you are done?

"Constitutional Health Questionnaire"

Name _____ Today's Date _____

Have you ever had (circle): Seizure Stroke Muscle tic Repeated explosive anger ?

Everyone is unique. To help determine the best dosage of LENS training, please rate the following statements by how frequently you are bothered by them:

BODY RECEPTIVITY

Frequency (0 = never, 10 = always)

- 1. I have sensations in my body when the weather is about to change. _____
- 2. I have a "textbook response" to treatments like acupuncture. _____
- 3. I can sense unhealthy environments before others—"a canary in a coal mine". _____
- 4. My body is more like a "delicate flower" (10) than a "hard-working ox" (0). _____
- 5. I am bothered by smells, lights or temperatures that others seem not to notice. _____
- 6. I can feel myself fighting off a cold or flu prior to having cold symptoms. _____
- 7. My "internal motor" idles at high speed. _____
- 8. I am bothered by experiencing other people's emotions in my body. _____
- 9. I have problems eating some foods. _____
- 10. I know quickly when something is going to work out, such as a job or relationship. _____
- 11. I have abilities that some people consider psychic. _____
- 12. I prefer a light touch to a deep massage. _____

REACTIVITY

I have **unpleasant reactions** to some:

- 1. Weather changes. _____
- 2. Foods. _____
- 3. Medications. _____
- 4. Smells, sounds or lights. _____
- 6. I can be shocked by my reactions—"Why did I say that?" _____
- 7. My friends/family sometimes find me difficult to be around. _____
- 8. I let people know how I feel about things. _____
- 9. I have a history of seizures, tics, migraines or stroke. _____

HARDINESS

- 1. I feel fine with weather changes, and winter doesn't make me SAD. _____
- 2. I have strong physical energy and stamina. _____
- 3. Thinking, planning and being with people energize me. _____
- 4. I have great endurance. _____
- 5. I can take any medication(s). _____
- 6. It takes a lot to upset me internally. _____
- 7. I keep working in spite of pain. _____
- 8. When life hits me hard, I recover quickly. _____

The CNS Functioning Assessment

Name _____ Today's Date _____

- | | | | |
|--|-----|-----------|----|
| Are you able to drive a motor vehicle? | Yes | Partially | No |
| Are you able to work or study? | Yes | Partially | No |
| Are you able to sustain a close relationship with someone? | Yes | Partially | No |

Below is a list of problems. **How frequently** are you currently **bothered** by them?
 Please pick a number from 0-to-10. "0" means *Not at all*, and "10" means *All the time*.
 If one or more of your parents had this condition, check the column headed by "Parents"
 If the problem came on suddenly, check the column head by "Sudden."

Sensory	(0 - 10) Frequent?	Parents?	Sudden?
Light, in general, or lights, bother you.	_____	_____	_____
Problems with the sense of smell.	_____	_____	_____
Problems with vision.	_____	_____	_____
Problems with hearing.	_____	_____	_____
Problems with the sense of touch.	_____	_____	_____
Emotions			
Problems of sudden, unexplained changes in mood.	_____	_____	_____
Problems of sudden, unexplained fearfulness.	_____	_____	_____
Problems of unexplained spells of depression.	_____	_____	_____
Problems of unexplained spells of elation.	_____	_____	_____
Problems with explosiveness.	_____	_____	_____
Problems with suicidal thoughts or actions.	_____	_____	_____
Clarity			
Feel "foggy" and have problems with clarity.	_____	_____	_____
Problems following conversations (with good hearing).	_____	_____	_____
Problems with confusion.	_____	_____	_____
Problems following what you are reading.	_____	_____	_____
Realize you have no idea what you have been reading.	_____	_____	_____
Problems with concentration.	_____	_____	_____
Problems with attention.	_____	_____	_____
Problems with sequencing.	_____	_____	_____
Problems with prioritizing.	_____	_____	_____
Problems not finishing what you start.	_____	_____	_____
Problems organizing your room, office, paperwork.	_____	_____	_____
You cover up that you don't know what was said or asked of you.	_____	_____	_____

LENS Intake Form

Energy (0 - 10) **Frequent? Parents? Sudden?**

Problems with Stamina

Fatigue during the day.	_____	_____	_____
Trouble sleeping at night.	_____	_____	_____
Problems awakening at night.	_____	_____	_____
Problems falling asleep again.	_____	_____	_____

Activation or Anxiety

Restlessness.	_____	_____	_____
Problems with irritability.	_____	_____	_____
Day Dreaming.	_____	_____	_____
Worrying.	_____	_____	_____
Always moving.	_____	_____	_____
Cold hands or feet.	_____	_____	_____
Palpitations.	_____	_____	_____

Memory

Forget what you have just heard.	_____	_____	_____
Forget what you are doing, what you need to do.	_____	_____	_____
Problems with procrastination and lack of initiative.	_____	_____	_____
Problems not learning from experience.	_____	_____	_____

Movement

Problems with paralysis of one or more limbs.	_____	_____	_____
Problems focusing or converging the eyes.	_____	_____	_____

Pain

Head pain that is steady.	_____	_____	_____
Head pain that is throbbing.	_____	_____	_____
Shoulder and neck pain.	_____	_____	_____
Wrist pain or knees.	_____	_____	_____
Tender areas of muscles.	_____	_____	_____
All-over pain.	_____	_____	_____
Joint pain.	_____	_____	_____

Other pain (specify) _____

LENS Treatment Consent

Areas of applicability: The LENS (Low Energy Neurofeedback System) has been successfully applied to central nervous system problems, such as symptoms of traumatic brain injury, stroke rehabilitation, fibromyalgia, depression and other mood and anxiety disorders, attention, hyper-activity, explosiveness/anger, and learning problems. Controlled studies on the LENS have been and are being conducted. Several university and medical human subjects review committees have reviewed the LENS treatment and have found it to be “minimally invasive.”

Effects of The LENS: The LENS tends to make functioning clearer and easier. It has increased cognitive functioning (memory, concentration, attention, ability to learn and to read, organizing, and sequencing), motivation (initiating and completing activities), and motor skills (coordination, balance, grace, recovery from paralysis). It has elevated mood as an antidepressant. It has improved sleep at night, and reduced sleepiness during the day. It has increased energy and stamina. It has reduced seizures, explosiveness, irritability, spasticity, and background anxiety. It has reduced migraine and fibromyalgia pain, as well as Restless Legs problems.

Side Effects: Although no significant negative side effects have been observed so far, the ones that we have seen will be discussed with you by your LENS Clinician; and your understanding of them will help you work with us to provide successful treatment. The side effects sometimes seen with the LENS are in the form of *temporary* increases of the symptoms you already have. If you experience any side effects, let your LENS Clinician know so that he/she can work closely with you to adjust the dosage. This is done the same way your medications are adjusted by your physician.

Medical Stability: You must be medically stable to engage in this treatment. Please tell your Clinician if you have any changes in medication, but especially any changes that could affect your medical stability. At times, your medical stability may be increased by reducing your medication. Your Clinician will ask you to consult your physician in these instances.

Other Treatments: Other forms of the LENS treatment can have roughly the same effects and side effects. No comparative studies have been conducted to permit objective evaluation of which is better, and under what conditions.

Discontinuing Treatment: You may discontinue treatment at any time for any reason. Should you wish to discontinue treatment, please inform your Clinician. He or she will cooperate and provide copies of any records for another therapist.

Privacy: Your treatment records are private to the fullest extent of the law; that is, except in cases of potential harm to yourself or others, or in civil or criminal proceedings and with a court order.

LENS Intake Form

Because people are individuals, success with the LENS is best predicted with a complete evaluation and the development of a treatment plan. The evaluation allows us to predict which symptoms will respond, and which may respond first. As with any treatment, there can be no guarantee of success in any particular instance. You are therefore invited to consent to be treated on the basis of this information.

Before you give your consent to be treated, we want you to ask as many questions as are necessary for you to understand this process. Please continue to express your questions, observations, and concerns at any time during the treatment process.

Consent to Treatment:

I have been informed of the effects, side effects, benefits, and risks of this treatment, and give my consent to participate in it.

Name

Date

Parent (if client is a minor)

Date