

# CNS Functioning Assessment

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Today's Date \_\_\_\_\_ Time \_\_\_\_\_ Diagnosis \_\_\_\_\_

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

**How frequently, in the past 24 hours, have you have problems in the following areas? 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, place a *P* in the column headed by "Parents?"**

**If the problem came on suddenly, put an *S* in the column head by "Suddenly?"**

	Frequency (0 - 10)	<i>Complete only once</i>	
<b>Sensory</b>		Parents?	Suddenly?
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	_____	_____	_____
<b>Emotions</b>			
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	_____	_____	_____
<b>Clarity</b>			
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	_____	_____	_____

	Frequency (0 - 10)	Parents?	Suddenly?
Problems not finishing what you start	_____	_____	_____
Problems organizing your room, office, paperwork	_____	_____	_____
Problems with getting lost in daydreaming	_____	_____	_____
You cover up that you don't know what was said or asked of you	_____	_____	_____
<b>Energy</b>			
Problems with stamina	_____	_____	_____
Fatigue during the day	_____	_____	_____
Trouble sleeping at night	_____	_____	_____
Problems awakening at night	_____	_____	_____
Problems falling asleep again	_____	_____	_____
<b>Activation or Anxiety</b>			
Restlessness	_____	_____	_____
Problems with irritability	_____	_____	_____
Day Dreaming	_____	_____	_____
Worrying	_____	_____	_____
Always moving	_____	_____	_____
Cold hands or feet	_____	_____	_____
Palpitations	_____	_____	_____
<b>Memory</b>			
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	_____	_____	_____
<b>Movement</b>			
Problems with paralysis of one or more limbs	_____	_____	_____
Problems focusing or converging the eyes	_____	_____	_____
<b>Pain</b>			
Head pain that is steady	_____	_____	_____
Head pain that is throbbing	_____	_____	_____
Shoulder and neck pain	_____	_____	_____
Wrist pain	_____	_____	_____
Tender areas of muscles	_____	_____	_____
All-over pain	_____	_____	_____
Joint pain	_____	_____	_____
Other pain _____(specify)	_____	_____	_____

# Sensitivity/Hardiness/Suppression Questionnaire

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Please answer each question with a number from 1 to 10 representing the amount of time in a day that one spends doing the item. One means at no time. Ten means all the time. Five means half the time.

## Sensitivity:

- \_\_\_\_\_ 1. I have a wide appreciation for tastes in different foods.
- \_\_\_\_\_ 2. I feel changes when the weather is about to change.
- \_\_\_\_\_ 3. I can easily tell when a medication is going to work or not, and tell much faster than most.
- \_\_\_\_\_ 4. I can sense smells and scents that others seem to not notice.
- \_\_\_\_\_ 5. I can sense my need for food by changes in my awareness, balance, or comfort level long before I feel hungry.
- \_\_\_\_\_ 6. I can sense mood, energy shifts, and attention changes, in those around me.
- \_\_\_\_\_ 7. I frequently know when something is going to work out – such as a job or relationship.
- \_\_\_\_\_ 8. Although I know when I'm in a toxic environment, I know it early and have the time to think about how to take care of myself.
- \_\_\_\_\_ 9. I know when I'm coming down with a cold or flu if I'm aware of slight increases in irritability, fogginess, or physical tightness not attributable to what's going on socially.
- \_\_\_\_\_ 10. I am very creative.
- \_\_\_\_\_ 11. I have to do things more slowly than others.
- \_\_\_\_\_ 12. I need time to do things at my own pace.
- \_\_\_\_\_ 13. I know the difference between quietness and stillness.
- \_\_\_\_\_ 14. I know the difference between relaxation and comfort.
- \_\_\_\_\_ 15. I select my companions, situations, and friends by the rapport that I feel when I'm with them.
- \_\_\_\_\_ 16. I have some abilities that some people consider psychic, but that I consider familiar.

## Reactivity:

- \_\_\_\_\_ 1. I can and do have strong reactions to foods.
- \_\_\_\_\_ 2. I can and do have strong reactions to weather changes.
- \_\_\_\_\_ 3. I can and do have strong reactions to medications.
- \_\_\_\_\_ 4. I can and do have strong reactions to smells.
- \_\_\_\_\_ 5. I can and do have strong reactions to sounds and lights.
- \_\_\_\_\_ 6. I can and do have strong reactions to not eating when I need to.
- \_\_\_\_\_ 7. I am suddenly shocked by my reactions - but then I remember, I do these kinds of things.
- \_\_\_\_\_ 8. My friends have a hard time being around me.

## Hardiness:

- \_\_\_\_\_ 1. I can do an amazing amount without fatigue.
- \_\_\_\_\_ 2. I can do an amazing amount without pain.
- \_\_\_\_\_ 3. I have no problems with the weather.
- \_\_\_\_\_ 4. I have no problems with foods.
- \_\_\_\_\_ 5. I have no problems with medications.
- \_\_\_\_\_ 6. It's hard to get me upset.
- \_\_\_\_\_ 7. People find me even tempered.
- \_\_\_\_\_ 8. I can work for long times.
- \_\_\_\_\_ 9. When something hits me hard, I recover quickly.

## Suppression:

- \_\_\_\_\_ 1. Things used to unpredictably have a big effect on me, but no longer do.
- \_\_\_\_\_ 2. I have almost forgotten how terribly embarrassing things used to be for me.
- \_\_\_\_\_ 3. My friends *used to* have a hard time being around me.
- \_\_\_\_\_ 4. I can't get as much done now as I used to.
- \_\_\_\_\_ 5. I find myself struggling in my mind

**Mid-Michigan Neurofeedback  
Patient Registration Form - LENS**

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Date: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Sex: F \_\_\_\_\_ M \_\_\_\_\_ Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Medicines Currently Taking:

Supplements Currently Taking:

Top symptoms: