

**REGISTRATION FORM**

CLIENT NAME: \_\_\_\_\_ GENDER: M F

PARENT'S NAME (if client is child) \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_

CELL PHONE: (\_\_\_\_) \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ MARITAL STATUS: S / M / D / W  
Month Day Year

EMPLOYMENT STATUS: Full time / Part time / Retired / Not employed

EMPLOYER: \_\_\_\_\_

WORK PHONE (\_\_\_\_) \_\_\_\_\_  
Is it all right if I call you at work? \_\_\_\_\_

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

Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ May I thank them? \_\_\_\_\_

Phone/Address \_\_\_\_\_

PHYSICIAN: Name, City, Phone: \_\_\_\_\_

I do not accept insurance. However, if you would like to submit your statements to your insurance company, I will be glad to provide whatever information they require.

Office use only:  
Client ID #: \_\_\_\_\_ Admission Date: \_\_\_\_\_ F: \_\_\_\_\_

**Mary St. Clair, MSW, LMSW, ACSW, BCIA-EEG**  
**Neurofeedback Therapy**  
3674 Oakleaf Road  
West Bloomfield, MI 48324  
**www.flexiblebrain.com**  
**248-366-6600**

***Change your Brain  
change your Life***

### **Consent for Treatment by Mary St. Clair**

**Several methods of treatment are described in this document. Mary St. Clair will make the decisions about which methods to use based on her clinical judgment during each appointment, and by your consent below:**

**Areas of Applicability:** The LENS has been successfully applied to central nervous system problems, such as symptoms of traumatic brain injury, stroke, 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. It has reduced symptoms of obsessiveness and compulsiveness. It has improved functioning in Autism.

**What is LENS?** LENS involves measuring and recording electrical signals (EEG: electroencephalogram) from the scalp, and using the frequencies of those signals to guide the speed of a feedback signal back to the brain. The feedback is extremely weak electromagnetic pulses from the EEG cables and will be neither visible nor feel-able.

The electromagnetic feedback is invisible. The intensity of our electromagnetic field is less than a trillionth of a watt and is on for a few seconds during each session. A background signal approximately a thousand times less than the feedback signal is also present as soon as the EEG begins to read the brainwaves. For reference, a cellular telephone generates a signal at least millions of times the power of the LENS feedback signal.

**The LENS procedure:** The brainwave recording process may require the use of a mild abrasive gel or witch hazel to clean the skin. Sensors will be applied to your head and ear, held there with a water soluble paste. No needles, shocks, skin penetrating, or other invasive procedures are used. The equipment assesses a client's brainwaves -- extremely faint electrical signals (EEG) measured at discrete locations on the scalp. The equipment itself then generates and delivers extremely faint, battery-generated signals that the brain may respond to in beneficial ways.

**Contraindications:** I do not recommend using LENS treatment if you are medically unstable. This includes if you are changing medications in order to become stabilized. It would be better to wait until you are more medically stable to use the LENS treatment. The same goes for if you are introducing several new treatments at once, it would be better to wait until you know the effects of the other treatments before starting LENS (or start LENS and wait on the other treatments).

**Side Effects:** The side effects sometimes seen with the LENS are in the form of *temporary* increases of the symptoms you already have. *Please let me know of any troubling symptoms. You may contact me by phone, email [mary@flexiblebrain.com](mailto:mary@flexiblebrain.com) or at your next session. I will work closely with you to adjust the dosage. This is done the same way your medications are adjusted by your physician.*

***If you have a history of seizures,*** it is important that you realize that starting LENS treatment will not abruptly stop your seizures. In other words, you will continue to have seizures as you have had them in the past until treatment begins to take effect. Furthermore, they may be more intense for periods of two to three weeks before they decrease in severity and frequency. This can be a cause of concern to those in your life, personal and professional. You are advised to speak with them about this issue and be aware of and comfortable with their potential reactions before you start.

When used properly, this LENS appears to have acted as an anticonvulsant and has led to medically supervised decreases in anticonvulsants. We urge you to consult your physicians and myself about your desires to decrease your medications of any kind.

***If you are taking certain medications,*** it will be necessary to stay in close contact with your physician. Your body may not need as much of the medication and you may start to experience the side effects of too much medication in your system. Keep this in mind if you take medications for diabetes, thyroid, migraines or headaches, seizures, spasticity, high blood pressure or emotional, perceptual or attention problems.

**You must inform me of all medications you use while you participate in the treatment, and you are not to change your medications without informing your physician and myself.**

**Brief Reactions:** On the rare occasions when the feedback is too intense or the feedback periods are too long, you may feel uncomfortable, irritable, tense and anxious. These feelings usually resolve within a few minutes or hours. When this happens, please tell me and the settings on the equipment will be changed to make the feedback less intense and shorter in duration, to the extent that you are once again more comfortable.

**Longer Lasting Reactions:** You may experience one day to two-week periods of anger, fear, and irritability during the treatment. You may feel as if you have tremendous energy to do things, or feel very tired. These longer-lasting reactions have tended to occur with people who have been struggling to control particular feelings for a long time. Support from your own therapist or physician may be useful and should be relied upon.

If you have some degree of spastic paralysis after a stroke or other brain injury, you should be treated with the **Photonic Stimulator** (consent below). The LENS treatment can cause spastic pain as the paralyzed muscles become more functional. The Photonic Stimulator will help to treat the spasticity so that you do not experience discomfort.

**Discontinuing LENS Treatment:** You may discontinue treatment at any time for any reason. It will be time to discontinue LENS when you stabilize and achieve consistently better functioning. Most of those who have received LENS have continued to improve long after LENS has ended. Should you wish to discontinue treatment, please inform me. I will cooperate and provide copies of any records for another therapist.

***I acknowledge that I have read and understand the above information. My consent to participate in LENS treatment is given voluntarily and without coercion. Initial here:\_\_\_\_\_***

### **Consent for the Use of the Photonic Stimulator (Infrared)**

**Description:** The Photonic Stimulator is an infrared light, and is classified by the FDA as a minimally invasive device. It generates an infrared light that is fairly strong: 1200 milliwatts. It is not visible.

**Uses:** The Photonic Stimulator is a light stimulation device that helps to re-tone your reactions to stimulation. The Photonic Stimulator can help to calm the nervous system when shown on the fingertips and toes. It can reduce muscle spasms when shown on the affected muscle groups. It can help tissue heal when shown on the affected tissues.

**Side effects:** Ordinarily if one is too sensitive for this light, as with any light, the temporary side effects can be fatigue and irritability. These effects usually wear off in a few hours to overnight.

**Contra-indications:** The photonic Stimulator is not to be used over cancerous tissue, nor shown in the eye. Very occasionally -- perhaps 3 out of every 100 instances -- someone has unusual reactions to many kinds of stimulation. If you are quite sensitive to various forms of stimulation, you may be quite sensitive and reactive to the Photonics Stimulation as well. In this case, use of the Photonics may be contraindicated.

**I give my permission to be treated by photonic stimulation. *Initial Here:* \_\_\_\_\_**

### **Consent for “Traditional” Neurofeedback:**

**Procedure for “traditional” EEG Neurofeedback.** One or more sensors are placed on the scalp and/or ears (with water-soluble paste) to act as sensors to pick up the client’s brainwaves, the electrical activity created in the brain. This electrical activity then passes through an amplifier to a computer where software is designed to give positive feedback via sights and sounds when the training conditions are met.

***I give my consent to be treated with Traditional Neurofeedback. Initial here:* \_\_\_\_\_**

### **Consent for HEG (Hemoencephalography)**

**Procedure for HEG (Hemoencephalography) Neurofeedback.** A headband containing either an infrared light source, or an infrared camera, is placed on the forehead, secured with Velcro. The brain blood flow measurement is sent to a computer, where software is designed to give positive feedback via sights and sounds when the training conditions are met.

***I give my consent to be treated with HEG. Initial here:* \_\_\_\_\_**

### **Consent for pRoshi Treatment:**

**Procedure for pRoshi:** The pRoshi glasses are either placed on the face, or left in front of the computer screen. The pRoshi simply flashes light at variable speeds. The varying speeds of the flashing light make the Roshi treatment safe, even if someone is prone to seizures due to strobe lighting. Roshi is a form of EDF (Electroencephalographic Disentrainment Feedback), which is a type of brainwave entrainment which uses variable light to disentrain or “reset” the brain’s activity to a more desired state. The brain goes about the task of correcting the apparent errors in its own patterns, seeking coherence, synchrony and balance. This effort calls for more energy, thus more blood flow and this increases the overall neurometabolism.

***I give my permission to be treated with pRoshi. Initial here:*\_\_\_\_\_**

## Consent for the Use of NeuroField

The NeuroField system is a variable direct current stimulation device that is designed to reduce stress and energetically balance the human body. NeuroField is designed to deliver small electrical pulses to the **energy field** that is generated by the human body. It is not physically connected to the body in any way. It is theorized that the energy field created by the body can absorb energy and deliver it to damaged molecular systems in the body. When the molecular systems are repaired they allow the natural wisdom of the body to engage its regenerative systems so as to promote stress reduction and healing. I understand that the thinking behind NeuroField is theoretical and has yet to be proven using the scientific method.

I understand that all protocols and services associated with the NeuroField are considered exploratory and experimental. I understand that this device does not have FDA approval as a medical device. I understand that there are no research studies showing the effectiveness of NeuroField at this time. At this time Mary St. Clair is not aware of any negative consequences from the use of the NeuroField. Should Mary St. Clair become aware of any negative treatment effects you will be notified immediately and given options regarding your treatment.

It has been documented that NeuroField can be very stimulating to the point of causing insomnia, but this has been observed in a very small population. NeuroField can cause fatigue and sleepiness. It can cause detox reactions. It is very important to drink 4oz of water every half hour for 3 hours after my Neurofield exposure. If these side effects occur I understand that I am to inform Mary St. Clair so that modifications can be made to my treatment in order to reduce or eliminate these issues.

*I understand that NeuroField helps to correct energetic imbalances. Procedures utilized include stress reduction protocols. I give my consent to be treated with NeuroField.*

*Initial here: \_\_\_\_\_*

***I acknowledge that I have been given an opportunity to ask questions regarding the all above treatments and that these questions have been answered to my satisfaction.***

***Initial here: \_\_\_\_\_***

***I understand that I may discontinue treatment at any time, and that I may refuse to consent without penalty. Initial here: \_\_\_\_\_***

***I understand that these treatments are not intended to diagnose neurological disorders, nor will a neurologist be reviewing these records. Initial here: \_\_\_\_\_***

***I understand that my treatment records are private to the fullest extent of the law; that is, except in cases of potential harm to myself or others, or in civil or criminal proceedings and with a court order. Initial here: \_\_\_\_\_***

***I give my full permission to Mary St. Clair, LMSW, to use any data collected during the preparation and participation in the LENS sessions, and I give up all implied and actual ownership of any data collected. I understand that when data is used, my confidentiality will be protected, and that my identity will not be revealed unless required by law. Initial here: \_\_\_\_\_***

***Mary St. Clair, LMSW has my permission to contact my physician or health care provider to both inform him/her of the circumstances and outcomes of my treatment, and request pertinent medical information about me. Initial here: \_\_\_\_\_***

***Cancellation policy: I understand that if I cancel the same day, or do not show for an appointment, Mary St. Clair may charge me a cancellation fee equal to my session fee. I understand that short-notice cancellations are acceptable for illness or unsafe driving conditions. Initial here: \_\_\_\_\_***

**Name of client: \_\_\_\_\_**

\_\_\_\_\_  
**Signature of client or Representative**

\_\_\_\_\_  
**Date**

## CNS Functioning Assessment

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

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

**How frequently do 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?"**

Sensory	Frequency (0 - 10)	<i>Complete only once</i>	
		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 with sudden changes in mood	_____	_____	_____
Problems with fearfulness	_____	_____	_____
Problems with spells of depression	_____	_____	_____
Problems with 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

**Mary St. Clair, LMSW**  
**Intake Summary Questions**

Name \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**Most Prominent Problems**

**How long been a problem?**

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**How were you before these problems occurred (if relevant)?**

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**Previous symptoms throughout your entire life:**

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**Current prescription medications, dose, reasons for taking them, and their effects on you:**

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**Current nutritional supplements, dose, (use back of sheet or separate sheet if needed):**

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**What other therapies, medications, treatments have you tried for your problem and what was the outcome? (Use back of sheet if necessary)**

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**How will you know you are done?**

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**Notice of Privacy Practices**  
**Receipt and Acknowledgment of Notice**

**Patient/Client Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Mary St. Clair's Notice of Privacy Practices (located at [www.flexiblebrain.com](http://www.flexiblebrain.com)). I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Mary St. Clair at 3674 Oakleaf Rd., West Bloomfield, MI 48324, 248-366-6600.

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*Signature of Patient/Client*

*Date*

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*Signature or Parent, Guardian or Personal Representative \**

*Date*

\* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.*

☐ ***Patient/Client Refuses to Acknowledge Receipt:***

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*Signature of Staff Member*

*Date*