Parent Pre-Evaluation Form

Name:_____

DOB:_____ Date:_____

Place a X next to any symptoms that are relevant:

- ❑ **My child has experienced de-realization or out-of-body experiences**
- ❑ **My child falls out of bed**
- ❑ **My child has episodes of unexplained twitching (face/arm twitches)**
- ❑ **My child has staring spells**
- ❑ **My child has had a head injury in the past**
- ❑ **My child has had a history of seizures**
- ❑ **My family has a history of seizures**

My child has experienced episodes of:

Tremor **Slurred speech** **Bad smell** **Fear**

Seeing flashing lights **Tingling** **Confusion** **Palpitations**

Dizziness **Loss of Consciousness** **Shaking uncontrollably**

Staring spells **Unresponsiveness** **Forgetfulness**

Tongue bites **Bed wetting** **Lip smacking** **Frequent Headaches**