



GENIUS BIOFEEDBACK CLIENT QUESTIONNAIRE

Name:

Date:

WHEN ANSWERING THESE QUESTIONS, PLEASE USE THE FOLLOWING SCALE:

- 0 - I do not experience this symptom or issue
- 1 - I experience it infrequently or very mildly
- 2 - I experience to a small degree, maybe a couple of times a week
- 3 - I experience this about 2-3 times per week
- 4 - I experience this on a fairly regular basis
- 5 - I experience this daily or fairly severely

***IMPORTANT:**
Please be sure to mark
the value , do not put
an "x"

PAIN	0	1	2	3	4	5
I have back pain						
I have neck pain						
I have joint pain						
My pain limits my daily activities						
I have headaches						
I have muscle aches						
I suffer from overall body pain						
I have migraine headaches						
I experience physical pain on a daily basis						
I need to take ibuprofen or another pain reliever on a regular basis						
I have generalized overall pain						
I have shoulder pain						
My pain limits my ability to enjoy life						
I have knee pain						
I experience plantar fasciitis (pain in the feet)						
My experience of pain affects my sleep						
TOTAL SCORE						



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SLEEP	0	1	2	3	4	5
I have trouble sleeping soundly through the night						
I have difficulty falling asleep						
I wake up during the night and have trouble falling back to sleep						
I do not wake up feeling rested						
I often feel like I want to sleep more hours						
I have sleep apnea						
I sleep very lightly						
I suffer from chronic insomnia						
I take an over the counter sleep aid						
I take a prescription sleep aid						
I wake up feeling more tired than when I went to sleep						
I wake up several times during the night						
I toss and turn in my sleep						
I typically need to sleep more than 10 hours each night						
It takes more than 1 hour for me to fall asleep						
I cannot fall asleep before midnight most nights						
My poor sleep is affecting other parts of my life						
TOTAL SCORE						

ENERGY	0	1	2	3	4	5
I feel like I don't have as much energy as I would like						
I need coffee or tea to get going in the morning						



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Low energy affects me on a daily basis						
I need energy drinks to sustain my energy						
I am tired during the day and need caffeine in order to do my work						
I don't feel I have enough energy to exercise						
When I try to exercise, I quickly become fatigued						
I experience low blood sugar during the day						
I feel good in the morning but my energy quickly dips						
I experience a low in energy around 3-5pm in the afternoon						
I get very tired after eating a meal						
I would like to have more energy during the day						
Having enough energy is an issue for me in my daily life						
TOTAL SCORE						

DIGESTION	0	1	2	3	4	5
My stomach is upset after a meal						
I feel uncomfortable after a meal						
I experience bloating on a regular basis						
I take Tums or something similar on a regular basis						
I have heartburn						
My food does not seem to digest well						
I find myself burping after a meal						
There are many foods I cannot tolerate well						



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I seem to have food allergies						
I avoid fatty foods and do not tolerate them well						
Flatulence is often an issue						
I have a bowel movement less than one time per day						
My bowel movements tend to be loose						
I suffer from constipation						
I have undigested foods in my stools						
I have eczema, dermatitis or psoriasis						
My heart races after certain foods						
I have muscle or joint aches and pain						
I have sinus drainage and phlegm or allergies						
I get full very quickly when I eat						
I feel nauseous after eating or other times						
My abdomen feels bloated or distended						
I get yeast infections or fungal infections						
I seem to react to foods no matter what I eat						
I suspect I have leaky gut						
I have back pain						
I experience diarrhea						
I don't have much energy during the day						
I have food allergies						
I have difficulty focusing during the day						
I feel I have brain fog						
I have difficulty losing weight						
TOTAL SCORE						



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WEIGHT, APPETITE AND BLOOD SUGAR	0	1	2	3	4	5
I feel that I need to lose weight but cannot lose it easily						
I feel tired or sleepy after eating a meal						
I find it hard to stop eating sometimes once I start						
I find that I am thirsty much of the time						
My appetite seems greater than it should be						
I crave sugary foods						
I crave fatty foods						
I have to eat many times during the day to keep my blood sugar stable						
No matter how little I eat, I cannot lose weight						
I tend to eat well during the day, but eat unhealthy / excess in the evening						
I know that I sometimes eat to calm my emotions						
No matter how hard I try, I cannot lose the weight						
TOTAL SCORE						

BRAIN AND FOCUS	0	1	2	3	4	5
I find it difficult to focus my attention on tasks I need to do						
My attention is easily lost to distractions						
I find that it hard to retain information after I read or watch it						
I experience brain fog						
I would like to have more mental clarity						
I forget sometimes why I walked into a room or where the keys are						
I find that stimulants like coffee or energy drinks help me to focus						
My memory is not as sharp as I would like for it to be						
TOTAL SCORE						
TOTAL SCORE ALL CATEGORIES						