

CASE STUDY

First Name: _____

Last Name: _____

Email: _____

Phone: _____ Age: _____

Which of the following have you used TouchPoints for?

*Select all that apply**

- | | | |
|---|---|---|
| <input type="checkbox"/> Aggressive Behavior | <input type="checkbox"/> Inability to Stay Calm | <input type="checkbox"/> Relationship Problems |
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Inability to Think Rationally | <input type="checkbox"/> Sensory Sensitivity |
| <input type="checkbox"/> Angry Outbursts | <input type="checkbox"/> Lashing Out at Others | <input type="checkbox"/> Separation Anxiety |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Meditation | <input type="checkbox"/> Sleep Issues |
| <input type="checkbox"/> Autism (Sensory Overload) | <input type="checkbox"/> Muscle Tension (Due to Stress) | <input type="checkbox"/> Social Issues |
| <input type="checkbox"/> Being Scared | <input type="checkbox"/> Negativity | <input type="checkbox"/> Stomachaches (Due to Stress) |
| <input type="checkbox"/> Breaking Bad Habits | <input type="checkbox"/> Negotiations | <input type="checkbox"/> Stress Relief |
| <input type="checkbox"/> Can't Get Started on Tasks | <input type="checkbox"/> Obsessing | <input type="checkbox"/> Supporting Friends |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Oppositional Behavior | <input type="checkbox"/> Tantrums |
| <input type="checkbox"/> Fear of the Dark | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Task Avoidance |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Performance Anxiety | <input type="checkbox"/> Test Anxiety |
| <input type="checkbox"/> Focus | <input type="checkbox"/> Pessimistic Thinking | <input type="checkbox"/> Therapy |
| <input type="checkbox"/> Frustration | <input type="checkbox"/> Phobias | <input type="checkbox"/> Tics |
| <input type="checkbox"/> Giving Bad News | <input type="checkbox"/> Physical Aggression | <input type="checkbox"/> Trichotillomania |
| <input type="checkbox"/> Headaches (Due to Stress) | <input type="checkbox"/> Physical Complaints | <input type="checkbox"/> Yelling, hitting, or hiding (Kids) |
| <input type="checkbox"/> Homework Avoidance | <input type="checkbox"/> Procrastination | <input type="checkbox"/> Other (Please provide more detail below) |

Other

Where do you wear TouchPoints? *

- On Wrists
- On Ankles
- Hold in Hands
- In or clipped to pant pockets
- Other (Please provide more detail below)

Other

How frequently do you use TouchPoints?

Please be as detailed as possible.

Example:

*"I use TouchPoints for my sleep issues once per day for 30 minutes right before bedtime.
I use TouchPoints for headaches due to stress once per week for 20 minutes." **

What significant changes have you seen? *

Have any medical providers, teachers, other family members etc. noticed a difference? *

Do you have any other markers demonstrating how TouchPoints™ are working (i.e. improved grades, lower blood pressure, better sleep per Fitbit or health trackers, using less medication, better sports performance, etc.)? *

Anything else you'd like to share? *