QEEG Report

Name:
Date of Birth:
Record Date:
Age:
Gender:
Handedness:

Referred by: Joan Ordmandy, MSEd, LPC

Diagnosis:

Summary Information

List Current Medication	Dose	Last Taken

Head Injury	N/Y
Loss of Consciousness?	N/Y
How long ago?	_____year_____month
Neurological Disease	N/Y
Convulsions	N/Y
Family History of Substance Abuse	N/Y
Drug Abuse / Addiction	N/Y
Alcohol Abuse / Addiction	N/Y
Memory Difficulties	N/Y
Confusion	N/Y
Depression	N/Y
Delusions, Hallucinations or Thought Disorder	N/Y
Learning Disability	N/Y
Previous EEG	N/Y
Hyperactivity, Attention or Impulse Control Problems	N/Y
Sickle Cell	N/Y

Time of testing:
Hours of sleep last night:
Time of last meal:

_____ec	Eyes closed relaxed
_____eo	Eyes open relaxed
_____eor	Eyes open reading task