BiofeedbackWORKS in Virginia PLLC

QEEG Recording Data

Client's Name:_____ Hours of Sleep the Previous Night:_____

Date of Birth:_____ Age:_____ Handedness:_____ Sex:_____

Date of Recording:_____ Time Recording:_____ QEEG #:_____

Current Medications & Dosage:	When were medications last taken? (Date & Time)

Circle either Y (Yes) or N (No) if there is a history or current presence of the following symptoms	History	Present
Head Injury (any form of head trauma…sports injuries, car accidents, falls)?	Y/N	Y/N
If you injured your head, did you **Lose Consciousness** (pass out)?	Y/N	Y/N
Neurological disease (Dementia, Parkinson's Disease, Alzheimer's Disease, Tremors, etc)?	Y/N	Y/N
Seizures (Convulsions)?	Y/N	Y/N
Sickle Cell	Y/N	Y/N
Drug abuse (Prescription and / or non-prescription)?	Y/N	Y/N
Alcohol abuse?	Y/N	Y/N
Memory Difficulties?	Y/N	Y/N
Family History of Substance and/or Alcohol Abuse	Y/N	Y/N
Confusion? (Disoriented to time (what month / year it is), place (where you are), identity (who you are)	Y/N	Y/N
Depression?	Y/N	Y/N
Delusions, Hallucinations, Thought Disorders?	Y/N	Y/N
Learning Disabilities? (Math, Reading, Spelling, Writing, etc.) (Please circle all that apply.)	Y/N	Y/N
If you have a learning disability/ies, **does it cause you to underachieve by at least two grade levels in two different subjects?**	Y/N	Y/N
Attention Problems (ADD / ADHD), Hyperactivity, Impulsivity (Circle all that apply)?	Y/N	Y/N
Sleep Problems	Y/N	Y/N
Anxiety	Y/N	Y/N
OCD Spectrum Symptoms	Y/N	Y/N
Autistic / Asperger's Spectrum Symptoms	Y/N	Y/N
Previous EEG	Y/N	Y/N

Tester Comments (Note any relevant client behaviors, issues with the EEG recording, etc.):

_____eo Eyes Open_____

_____

_____ec Eyes Closed _____

_____

Task? _____

Equipment (amplifier type) used to record the raw EEG?(circle): Discovery 24 Freedom

QEEG Technician:_____ Cap Used: _____