qEEG Patient Flow Sheet

Clinician Information

First, MI, Last name: Juanita F. Jussenhoven, MA License(s)/Certification(s): LPC Candidate, NCC

Patient Information

Last Name: _____

First Name: _____

Middle Initial: _____ Patient ID#: _____ Handedness: Left / Right / Ambi

Date of Birth (mm/dd/yyyy): _____

Date, time, and place of recording: _____

Hours of sleep the night prior to the recording: _____ Was the sleep restful? Yes / No

Are there any current psychiatric diagnoses? Yes / No If yes, what are they? _____

_____

Medications: _____

_____

Supplements: _____

_____

Were any of the above taken on the day of the recording? Yes / No Which?: _____

_____

Is there a history of Head Injury? Yes / No

If yes, please provide approximate date of the injury, that age of the patient at the time of the injury, the severity of the injury, and any loss of consciousness: _____

_____

_____

_____

Is there a history of learning disability? Yes / No If yes, which one(s)? _____

_____

Developmental History – Please indicate your (or your child's) history in relation to the following:

Prenatal and Birth	**Yes**	**No**	**If yes, please provide details on page 4**
Prenatal stress or injury	___	___	
Prenatal drug/alcohol exposure	___	___	
Prenatal tobacco exposure	___	___	
Birth trauma (forceps, breech, Cesarean, etc.)	___	___	
Anesthesia or pain medications at delivery	___	___	
Anoxia (oxygen deprivation at delivery)	___	___	
Premature / Late delivery	___	___	
Medical complications post-partum	___	___	
Birth weight: _____lbs _____ oz.s			
Was the patient adopted?	___	___	If yes, at what age? _____

Growth and development – Please indicate:	**On time**	**Early**	**Late**
Walking (9-12 mo.s – 13-17 mo.s - > 18 mo.s)	_____	_____	_____
Talking (20+ words @ 18-20 mo.s is typical)	_____	_____	_____
Feeding self (18-24 mo.s is typical)	_____	_____	_____
Jumping (25-28 mo.s is typical)	_____	_____	_____
Walk stair unassisted (25-30 mo.s is typical)	_____	_____	_____
Walk stair alternating feet (36 mo.s is typical)	_____	_____	_____

Medical Conditions of Childhood:	**Yes**	**No**	**Please indicate what condition(s)**
Allergies and/or Food sensitivities	___	___	_____
Infections of the eyes, ears, or throat	___	___	_____
Fevers greater than 104^0	___	___	_____
Measles, Mumps, Rubella, Whooping Cough	___	___	_____
Reactions to medications or vaccinations	___	___	_____

Trauma	Yes	No	If yes, please provide details (age at trauma)
Loss of consciousness for any reason	___	___	_____
Accidents requiring ER or doctor visit	___	___	_____
Serious illness requiring hospitalization	___	___	_____
Any infection of the Central Nervous System	___	___	_____
Any disease of the CNS (MS, Lupus, etc.)	___	___	_____
Accidental overdose or poisoning	___	___	_____
Intentional overdose	___	___	_____
Stroke /Cerebral tumor or cyst	___	___	_____
Chemotherapy ***or*** general anesthesia	___	___	_____
Are you a combat veteran?	___	___	_____
Death in the family or close friend	___	___	_____
Divorce / Remarriage	___	___	_____
Sexual / Verbal / Physical / Emotional Abuse	___	___	_____

Symptom Checklist – Please indicate if the patient and/or family members (parents, brothers, sisters, grandparents) currently experience or have a history of any of the following:

Symptom	√ if patient	√ if family	√ if current	Ever treated for this?	Yes	No
Headaches	_____	_____	_____		___	___
Dizziness	_____	_____	_____		___	___
Frequently ill	_____	_____	_____		___	___
Poor Appetite	_____	_____	_____		___	___
Sleep < 7 hrs regularly	_____	_____	_____		___	___
Sleep > 10 hrs regularly	_____	_____	_____		___	___
Emotional eating	_____	_____	_____		___	___
Allergies	_____	_____	_____		___	___
Food sensitivities	_____	_____	_____		___	___
Celiac disease	_____	_____	_____		___	___
Heart palpitations	_____	_____	_____		___	___
Stomach/GI problems	_____	_____	_____		___	___
Asthma	_____	_____	_____		___	___
Seizures (at any age)	_____	_____	_____		___	___
Drug/alcohol use/abuse	_____	_____	_____		___	___
Chronic fatigue	_____	_____	_____		___	___
Chronic Pain	_____	_____	_____		___	___
Fibromyalgia	_____	_____	_____		___	___
PMS	_____	_____	_____		___	___
Depressed mood	_____	_____	_____		___	___
Hopeless/helpless/worthless	_____	_____	_____		___	___
Anxiety	_____	_____	_____		___	___
Excessive worry	_____	_____	_____		___	___
Panic attack	_____	_____	_____		___	___
Phobias	_____	_____	_____		___	___
Negative thoughts about self	_____	_____	_____		___	___
Negative thoughts about others	_____	_____	_____		___	___
Repetitive thoughts	_____	_____	_____		___	___
Thoughts of harm to self	_____	_____	_____		___	___
Thoughts of harm to others	_____	_____	_____		___	___
Problems with concentration	_____	_____	_____		___	___
Problems staying on task	_____	_____	_____		___	___
Problems with hyperfocus	_____	_____	_____		___	___
Easily distracted	_____	_____	_____		___	___
Low motivation	_____	_____	_____		___	___
Poor task completion	_____	_____	_____		___	___
Impulsivity	_____	_____	_____		___	___
Hypermotor activity	_____	_____	_____		___	___
Need to be moving to focus	_____	_____	_____		___	___
Irritability	_____	_____	_____		___	___
Anger or Rage	_____	_____	_____		___	___
Temper tantrums	_____	_____	_____		___	___
Verbal aggression	_____	_____	_____		___	___
Physical aggression	_____	_____	_____		___	___
Inability to relax	_____	_____	_____		___	___
Age inappropriate behaviors	_____	_____	_____		___	___
Sexual difficulties	_____	_____	_____		___	___
Inappropriate sexual behaviors	_____	_____	_____		___	___
Engages in self-medicating	_____	_____	_____		___	___

If you answered Yes to any question, please provide amplifying information in the space below. This information, such as approximate date and age when the event occurred and specifics of what occurred, will assist in the assessment of your unique circumstances in order that we may provide training recommendations that are tailored to you or your child.

Prenatal and Developmental History: _____

Medical Conditions and Treatment History: _____

Trauma History and Treatment of Trauma: _____

Brain Health and Treatment History of Brain-based problems: _____