Peterson Clinic

Caring for the Whole Person…Naturally!

QEEG INTAKE

Patient's Name:____ **Date**:___________________

Gender: M F **Dominant Hand:** L R **Birth Date:**__________ **Age:**______

Medications:____

Were any medications taken 12 hours prior to Qeeg? NO YES

If yes, list medication and time taken____

History of past recreational drug use? Y N If yes, what drug(s)______________________________

Date & Time of last meal: ____

Sleep: How was your sleep last night?______________ I had ______hours of sleep last night

Today I feel: Extreme Fatigue Moderate Fatigue Slightly Tired Rested

I fall asleep within: 0-30 min. 30-60 min 1-2 hrs. 2 or more hrs of going to bed.

I awaken: 0 1 2 3+ times per night

If I awaken, I can return to sleep within: 10 min - 30 min – 1hr - 1-2hrs 2+ hrs or not at all

What keeps you awake? Pain Racing Thoughts Night Terrors Restless Legs

Body Discomfort Temperature (yes, this includes night sweats)

Other? ____

Birth Trauma: Blue baby? Y N Cord around neck? Y N Failure to thrive? Y N

Other complications of pregnancy or delivery?____

Head Injury: YES NO If yes, was there loss of consciousness? Y N

If yes, how long were you unconscious? ____

Were you hospitalized? Y N If yes, for how long?____

What part of head was injured? Left Right Front Back side__________________________

Was there a fracture? Y N If yes, what was fractured? __________________________________

If no LOC, what symptoms did you have? ____

Have you had more than one head injury? YES NO

Please list the dates and cause of head injuries____

____

What symptoms do you still have?____

List any diagnosis that you were given in relationship to your brain, mood or function._______________

____

Any other pertinent information you wish to share with us?____

____

DATE OF TEST ________ **TIME OF TEST**_________ **THERAPIST** ______

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