Bona Dea Centre
38 Wilton Avenue, Bryanston
Tel: 011 514 0738
Fax: 086 551 8775
justine@bonadeacentre.co.za
www.bonadeacentre.co.za

Name of person filling in this form: _____

Contact number: _____

Patient's name: _____

Date of birth of patient: _____

Handedness: LEFT / RIGHT / BOTH

Drugs, supplements, and herbal remedies taken in the last 7 days:

DRUG	DOSE	PRESCRIBING PHYSICIAN	WHEN LAST TAKEN

Is there a history of seizures or head injury? YES / NO
If yes, please describe

_____
_____
_____

If a psychiatric or other diagnosis has been given, please state below:

_____
_____
_____

Please list the main concerns regarding the person coming for the QEEG. Include emotional, behavioural, academic challenges.

_____
_____
_____
_____
_____

Has an EEG been done previously? If so, what were the results? -

_____

_____

Did you have breakfast this morning? YES / NO

Consent

I, _____, parent / guardian of

_____

(if applicable) give consent to the collection of EEG data by Justine Loewenthal. I am aware that it is necessary to place electrodes on the scalp.

I confirm that I have read through and understand the contents of the QEEG information document and have clarified any uncertainties.

I ***give / do not give*** consent for Justine Loewenthal to discuss the findings of the EEG and QEEG with other professionals and / or teachers involved with the patient, if the patient is a child.

_____ _____

Signature Date