BIOSERENITY | EEG COGNITIVE ASSESSMENT

Patient Name _____ Date of Birth _____

Phone _____ Today's Date _____

Doctor's Name _____

Please complete this form and take it with you to your doctor.

HAVE YOU EVER EXPERIENCED:

If Yes, please select how often symptoms listed below are occurring, either daily, weekly, or monthly:

Sensation of not feeling right, being a little confused or unsteady?	☐ Yes ☐ Daily	☐ No ☐ Weekly	☐ Monthly
Spells you would describe as feeling faint or as if you might pass out?	☐ Yes ☐ Daily	☐ No ☐ Weekly	☐ Monthly
Events where you have experienced altered or decreased awareness?	☐ Yes ☐ Daily	☐ No ☐ Weekly	☐ Monthly

HAVE YOU EVER EXPERIENCED:

If Yes, please select how often symptoms listed below are occurring, either daily, weekly, or monthly:

Episodes of temporary confusion or brain fog?	☐ Yes ☐ Daily	☐ No ☐ Weekly	☐ Monthly
Dizziness accompanied by loss of awareness or confusion?	☐ Yes ☐ Daily	☐ No ☐ Weekly	☐ Monthly
Difficulty finding the right words or expressing yourself?	☐ Yes ☐ Daily	☐ No ☐ Weekly	☐ Monthly
Lapse of time or zoning out:	☐ Yes ☐ Daily	☐ No ☐ Weekly	☐ Monthly
Difficulty recalling the details of conversations you just had or TV shows you just watched?	☐ Yes ☐ Daily	☐ No ☐ Weekly	☐ Monthly

HAVE YOU EVER EXPERIENCED:

Are you experiencing migraines associated with the following symptoms?

Strange sensations or flashing/shimmering lights, zigzagging lines, or stars	☐ Yes ☐ Daily	☐ No ☐ Weekly	☐ Monthly
Dizziness	☐ Yes ☐ Daily	☐ No ☐ Weekly	☐ Monthly
Loss of awareness/consciousness	☐ Yes ☐ Daily	☐ No ☐ Weekly	☐ Monthly
Nausea	☐ Yes ☐ Daily	☐ No ☐ Weekly	☐ Monthly

DO YOU HAVE A HISTORY OF:

TBI (Traumatic Brain Injury)	☐ Yes	☐ No
TIA (Transient ischemic Attack/ Mini-Stroke)	☐ Yes	☐ No
Brain concussion or Post-concussion syndrome	☐ Yes	☐ No
Dementia	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Brain Injury, surgery, or tumors	☐ Yes	☐ No

PHYSICIAN/OFFICE USE ONLY

Notes:
Onset:

Patient Signature _____ Date _____