LORI CODA LLC
Lori Coda MS, SpEd
Neurofeedback & QEEG Specialist
3 Hollyhock Lane • Wilton, CT 06897 • 203.529.3300
loricoda@gmail.com

QEEG

What to bring:

1: Please bring the following forms:
- **signed consent forms**
- **medication/supplement forms**
- **completed intake form/symptom tracking checklist**
- **choice of payment option forms**
- **credit card information form**

* **all forms can be downloaded from** *www.drohara.com*

2: Two of your child's favorite DVD's

3: Comfort items
a favorite blanket, stuffed animal, etc.
***please no cause and effect toys**

4: Any type of reinforcers that are not battery operated or electrical

5: Food/drinks can only be used as a last resort

6: Your patience!

7: No siblings please

*** Please note that your child will have to wear an electro-cap for the entire procedure. There are 19 electrode placements. Electo-gel is used for impedance of the electrodes. Your child will leave with some gel stuck in his/her hair.**
The gel can be cleaned by washing your child's hair when they return home

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Informed Consent for Quantitative EEG or Brain Mapping

Lori Coda offers EEG (brain wave) biofeedback (neurofeedback) training to clients requesting such services. Because each person's condition or reason for seeking a change in brain functioning is different, it is important to know at what exact sites and for how long to perform EEG biofeedback in order to maximize the brain's performance.

Clearly, it is important to have a baseline measure of brain functioning in order to determine the precise EEG Biofeedback training specifications. We use a brain map (Quantitative EEG) in planning the best training strategy as well as measuring the outcome of EEG biofeedback training.

A Quantitative EEG (QEEG) is a procedure where the technician will apply 21 electrodes to your scalp and record the electrical activity of your brain. The instruments are merely measuring devices similar to an EKG. Sensors are placed on the surface of the head which then record minute electrical signals generated by your brain. A computer records these signals and this data is then sent for analysis.

I have been advised to continue ongoing therapies until otherwise advised directed by my physician.
After the EEG data has been collected it will be analyzed by both specialists in QEEG and a neurologist. This report will help guide the diagnosis and treatment interventions.

Lori does not make diagnoses solely on the basis of the QEEG report, rather in combination with a comprehensive medical evaluation, diagnostic testing, necessary labs along with a neurologist report of the EEG recording. The neurologist is solely responsible for their diagnostic findings, impressions and recommendations.

My physician has explained the procedure and addressed my questions and concerns.

When you sign this form, you are indicating that you understand the information that it contains. When you agree to participate in this program, you or your child are not obligated to complete the training if for any reason you believe it is not in your or your child's best interest. This means you may discontinue participation at any time. Training and test results will be available to clients and/or parents.

_____ **Yes, I consent to receive a QEEG. I understand and agree to the terms of this document.**

I give my permission to use the EEG recording, quantitative brain maps, and test measurements for educational and research purposes. There will be no identifying information regarding your identity (i.e. name, initials, etc.).
_____ **Yes, I understand and agree to allow my non-identifying data to be used in education and research**

The QEEG analyst and neurologist who review the QEEG data may require a medical history to help make the report clinically relevant. For this purpose, we would like to provide them with clinical information we gather during the medical intake.

Name of Client: _____ **Birthdate:**_____ **Phone #:** _____

Client Signature:_____ **Date:** _____

Parent/Guardian Name (if client is a minor): _____ **Phone #:** _____

Parent/Guardian Signature:_____ **Date:** _____

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Intake History

Name of Client:_____**Age:**_____**DOB:**_____

Address:_____

City/State/Zip:_____

Phone: (home)_____**(work)**_____**(cell)**_____**(fax)**_____

Parent(s) or Guardian(s) of minor:

Name(s):_____**Age:**_____**DOB:**_____

Address:_____

City/State/Zip:_____

Phone: (home)_____**(work)**_____**(cell)**_____**(fax)**_____

Physician/other health care professional (chiropractor, therapist, naturopath, bodyworker, etc):

Name:_____**Phone:**_____

Referral source if referred to this office:_____ **Phone:**_____

What benefits do you hope to gain from EEG Neurofeedback:

_____
_____
_____
_____
_____
_____
_____
_____

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

Prenatal and Birth	**YES**	**NO**	**Details**
Prenatal Stress or injury	____	____	_____
Prenatal drug/alcohol exposure	____	____	_____
Birth trauma (forceps, breech etc.)	____	____	_____
Anesthesia, pain medications	____	____	_____
Anoxia (oxygen deprivation @ birth)	____	____	_____
Premature/late delivery	____	____	_____
Medical problems after birth	____	____	_____

Birth weight_____adopted at age_____other_____

Growth and Development	**Typical**	**More**	**Less**	**Details**
Activity Level	_____	_____	____	_____
Motor/coordination development	_____	_____	____	_____
Infections/allergies	_____	_____	____	_____
Emotional development	_____	_____	____	_____
Behavioral concerns	_____	_____	____	_____
Handedness development	_____	_____	____	_____
Appetite/digestion	_____	_____	____	_____
Language/Speech development	_____	_____	____	_____

Physical Traumas	**YES**	**NO**	**Details**
Head injury (even minor falls, etc.)	____	____	_____
Coma (loss of consciousness)	____	____	_____
Accidents (list all)	____	____	_____
High Fever	____	____	_____
Serious illness	____	____	_____
Surgery	____	____	_____
CNS infection	____	____	_____
Drug overdose/poisoning	____	____	_____
Recreational drug use	____	____	_____
Anoxia	____	____	_____
Stroke	____	____	_____

Psychological Stress/Life Changes	**YES**	**NO**	**Details**
Death in Family	____	____	_____
Divorce/Remarriage	____	____	_____
Move/Relocation	____	____	_____
School change	____	____	_____
Job Change	____	____	_____
Family member chronic illness	____	____	_____

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Please indicate if the **client** and/or **family member(s)** (parents, grandparents, brothers, sisters, aunts, uncles and or children) **currently experience** or have a **history** of any of the following symptoms:

Symptom	✓client	✓family	✓if current
Feeling tense			
Depressed			
Always the on go			
School/work problem			
Impulsivity			
Hyperactivity			
Attention problems			
Behavioral problems			
Vocal or motor tics			
Sleep problems			
Legal trouble			
Headaches			
Feeling lonely			
Frequent Illness			
Repetitive thoughts			
Repetitive behavior			
Inferior feelings			
Dizziness			
Fainting spells			
Heart palpitations			
Stomach trouble			
Poor appetite			
Picky eater			
Nightmares			
Alcohol/drug problem			
Feeling Panicky			
Tremors			
Suicidal ideas			

Symptom	✓client	✓family	✓if current
Shy with people			
Allergies			
Asthma			
Seizure/Epilepsy			
Chronic pain			
Food sensitivity			
Head Injuries			
Memory Problems			
Temper tantrums			
Rages			
Verbal aggression			
Physical aggression			
Stubbornness			
Addictions			
Bowel disturbances			
Chronic fatigue/FMS			
PMS			
Physical/sexual abuse			
Over ambitious			
Unable to relax			
Can't make decisions			
Communication prob.			
Problems at home			
Financial Problems			
Any Chronic Illness			
Other			

Please circle the FIVE CURRENT PROBLEMS listed above that are the MOST DISTRESSING to you or your child.

Therapist comments:

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QEEG/Neurofeedback
Medication Supplement List

PATIENT: _____

DOB: _____

DATE: _____

Please any/all medications and supplements that your child is taking:

Medications:	***Supplements:***

Parent Signature: _____ ***Date:***

notes - for office use only:

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CREDIT CARD INFORMATION

NAME:_____
(print name as it appears on credit card)

Please select type of credit card and fill in requested information:

❏ Visa Card: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Expiration date: _____Three Digit Security Code on back:__ __ __

❏ Master Card: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Expiration date: _____Three Digit Security Code on back:__ __ __

I_____ give Lori Coda,LLC permission

(Please print name)

to use the credit card listed above to pay for the following services:

_____ QEEG _____Neurofeedback

Parent Signature: _____Date:_____

Payment Options Attached

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Informed Consent for Biofeedback/EEG Neurofeedback Training

Lori Coda offers EEG (brain wave) biofeedback (neurofeedback) training to clients requesting such services. The training is offered to children and adults, either self referred or identified by parents, physicians, teachers or other referral sources as having conditions shown to be responsive to this training. These conditions are generally thought to be those that appear to be associated with irregular brain activity where there is also clinical and research evidence to suggest neurofeedback training as a viable approach.

Our staff has education, training and experience in neurofeedback and in EEG technology in addition to related professional disciplines such as psychology and naturopathic medicine. Lori recommends the training on the basis of our observations of improvement in clients with similar conditions. Scientific investigation is ongoing to determine the mechanism by which these improvements are achieved and therefore EEG neurofeedback is considered by many to be experimental at this time. We use standard methods to determine the proper neurofeedback training program and to measure progress during and after training. Neurofeedback is, however considered an experimental approach and therefore we need client or parental informed consent for this training.

We do not claim that you or your child will improve from the neurofeedback training. However, test results indicate that more than 80% of clients improve on at least one test scale and more than half improve on three out of four scales. A few clients who seem to get better at first may find that the improvement does not last after the training ends. Such clients may benefit from regular follow-up sessions. Some individuals may not experience any effects at all from the training. Our staff is always happy to discuss client progress. Other methods may also be effective for you or your child. We will be happy to provide information about such services at your request. Individual and/or family counseling may help you and/or your child integrate the gains from neurofeedback into everyday family, social, school and work environments.

Neurofeedback training has been the subject of more than 30 years of research and clinical study. The training appears to be harmless as far as is known at present and no injuries have been reported in the experience of Lori Coda, or in a review of research literature. Neurofeedback does not do anything to your child. It is not a treatment; it is a training process. The instruments are merely measuring devices similar to a thermometer. Sensors are placed on the surface of the head and your child is given information about what is being measured. Nevertheless, beyond this, Lori Coda does not make any representation concerning the safety or effectiveness of the training. Neurofeedback training has not been evaluated by the FDA. Neurofeedback does not diagnose, treat or cure any disease. Any questions should be addressed to one's personal physician. Clients should continue ongoing therapies until otherwise advised by a physician.

When you sign this form, you are indicating that you understand the information that it contains.

When you agree to participate in this program, you or your child are not obligated to complete the training if for any reason you believe it is not in your or your child's best interest. This means you may discontinue participation at any time. Training and test results will be available to clients and/or parents.

Yes, I understand and agree to the terms of this document.

Name of Client: _____ Birth date: _____Phone #: _____

Client Signature _____
Date _____:____
:
Parent/Guardian Name (if client is a minor):_____ Phone #: _____

Date _____

: