

Thank you for contacting the Brain Bio Centre. This is the first clinic of its kind in Britain to offer comprehensive diagnostic and nutrition-oriented treatment for those with mental health concerns.

After 20 years research at the Institute for Optimum, working with literally thousands of clients, we feel confident to say that this approach is highly effective. It should, in our opinion, be the first port of call, not the last, for a wide range of mental health concerns including autism, schizophrenia, depression, anxiety, bipolar disorder, learning difficulties, dyslexia, dyspraxia, dementia, and Alzheimer's disease.

If you are relatively new to optimum nutrition and its proven benefits for mental health I strongly recommend you read my book, Optimum Nutrition for the Mind. This book also contains 500 scientific references showing how effective this approach is and is the best background reading for yourself and your doctor, should you want to inform them about this approach. You will also be able to read a small number of the hundreds of success stories from former clients, both children and adults. The book is available in any bookshop or by mail order by calling 020 8871 2949 or by visiting www.brainbiocentre.com. This book gives you invaluable information to support you through your Brain Bio Centre treatment.

If you would like to come and see us, please complete the Patient Information Questionnaire, which is included, and return it to us with a signed copy of the Terms and Conditions, and a payment of £50, which will be used as a deposit towards your first appointment.

Once we receive your Questionnaire, we will contact you to arrange an appointment at our Clinic in Richmond, south west London.

May I take this opportunity to wish you the very best of health and let you know that my team and I will do our utmost to bring you to the point of optimal health.

Yours sincerely



Patrick Holford

Director of the Brain Bio Centre

Founder of the Institute for Optimum Nutrition

BRAIN BIO CENTRE at the Institute for Optimum Nutrition



The Brain Bio Centre is an outpatient clinical treatment centre, specialising in the 'optimum nutrition' approach to mental health problems. The centre offers a comprehensive assessment of biochemical imbalances that can contribute to mental health problems, plus advice to correct these imbalances as a means to restore health. The Clinic is located at the Institute for Optimum Nutrition, founded by Patrick Holford in 1984.

Conditions That May Be Helped

We work with any person who has a mental health concern. A wide variety of mental health problems have been helped through the optimum nutrition approach. These include depression, anxiety, bipolar disorder, schizophrenia, 'brain fog', fatigue, learning difficulties, dyslexia, dyspraxia, autism, dementia, and Alzheimer's disease.

The Treatment

As a treatment centre of excellence, patients are accepted on the basis of being willing to have a thorough mental health and biochemical assessment and to follow through with nutritional management under medical supervision, over a minimum of a six month period.

Consultations

The initial appointment usually takes one hour. Subsequent appointments with the clinical nutritionist are generally for half an hour.

A 20 minute appointment with our psychiatrist may be required for some people prior to the Initial Appointment with the clinical nutritionist.

A more extensive Psychiatric Assessment appointment with the doctor is also available to anyone at any time.

In general, most people meet with a clinical nutritionist three to four times over the course of about six months. They may also meet with the psychiatrist once or twice.

Location

The Brain Bio Centre is located at the Institute for Optimum Nutrition (ION), Avalon House, 72 Lower Mortlake Road, Richmond, Surrey TW9 2JY.

Tests

Biochemical screening through blood, urine and hair samples, may include:

Food allergies using quantitative ELISA IgG analysis

Mineral imbalances using hair, sweat and blood mineral analysis

Pyroluria using urinary reagent analysis

Neurotransmitter imbalances using blood platelet determinations of serotonin, noradrenalin, histamine and plasma acetylcholine

Homocysteine imbalance using blood plasma

Essential fatty acids using red blood cells

Urinary peptides using urine analysis

Further tests to investigate specific issues may also be recommended where appropriate.

Psychometric screening involves straightforward questionnaires, completed prior to the first consultation.

Costs

The cost of the programme will vary from patient to patient, depending on the tests, consultations and nutritional supplements required.

Over several months, most patients spend between £600 to £1100 on consultations and tests, plus between £2 and £3 per day for supplements. The supplement programme varies from person to person and is reassessed and adjusted as the patient progresses.

Appointments

To arrange an appointment for a consultation at the Brain Bio Centre, call 020 8332 9600.

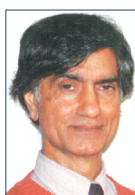
People



Patrick Holford BSc, DipION, the clinic director, trained in psychology in the 1970s and went on to specialise in the nutritional treatment of mental health problems. He became a student of Dr Carl Pfeiffer in Princeton, New Jersey, and Dr Abram Hoffer, former psychiatric research director in Canada. He is the UK representative of the International Society for Orthomolecular Medicine. Since the 1970s Patrick Holford has successfully treated thousands of patients and carried out original research on schizophrenia and learning difficulties, including ground-breaking research in the mid-80s that proved that vitamin supplements could increase IQ scores in children. He is author of the book *Optimum Nutrition for the Mind* and is regularly called upon as the nutrition expert for radio and television features. Patrick Holford is a Fellow of the British Association for Nutritional Therapy.



Professor André Tylee MB BS MD FRCGP MRCPsych is the external research adviser for the Brain Bio Centre. Dr Tylee is the Professor of Primary Care Mental Health, and Chairman of the Primary Care Research Group at the Institute of Psychiatry. He has established a Mental Health and Nutrition Special Interest Research Group comprising a range of researchers and clinicians in primary care, secondary care, social care and the Brain Bio Centre which meets regularly to review existing research in the area and to prioritise future research projects for funding applications.



Dr Shauki Mahomed LRCPandS(I), DPM, MRCPsych is the Brain Bio Centre psychiatrist. He qualified at the Royal College of Surgeons in Dublin and also works in the NHS. He is a specialist in Psychological Medicine and has vast experience in many aspects, both dynamic and organic. He is a firm believer in the importance of nutrition, firstly, as a key part of any health programme and, secondly, to maximise the treatment in the event of illness.



Lorraine Perretta DipION is a clinical nutritionist trained at the Institute for Optimum Nutrition. She is author of the book *Brain Food* and specialises in the nutritional management of mental health problems. Lorraine is a member of the British Association for Nutritional Therapy.



Deborah Colson DipION is a clinical nutritionist trained at the Institute for Optimum Nutrition. She specialises in the nutritional management of mental health problems and is co-author of *Optimum Nutrition for your Child's Mind* and *The Alzheimer's Prevention Plan*. Deborah is a member of the British Association for Nutritional Therapy.



Lol Willcocks is the clinic manager. She works with patients to organise appointments, arranges biochemical testing with laboratories, and handles all administrative matters.

We work together as a team to ensure you receive the best possible care and attention.

The Mental Health Project board of advisors includes:

- Lady Diana Whitmore** (psychotherapy)
- Dr Abram Hoffer** (schizophrenia)
- Dr James Braly** (addictions, food allergy, gluten sensitivity and methylation abnormalities)
- Dr Tapan Audhya** (neurotransmitter testing)
- Dr Neil Ward** (clinical chemistry)
- Dr Hyla Cass** Assistant Clinical Professor of Psychiatry at UCLA School of Medicine (nutritional psychiatry)
- Amelia Mustapha** (Depression Alliance)
- Sally Bunday** (Hyperactive Children's Support Group)
- Professor A. David Smith** D Phil (Alzheimer's Disease)

For more detailed information on the Brain Bio Centre and the 'optimum nutrition' approach to mental health:

- Visit www.brainbiocentre.com
- Purchase an Information Pack by sending a cheque for £4.99 payable to the Brain Bio Centre Avalon House, 72 LowerMortlake Road, Richmond, TW9 2JY. Telephone **020 8332 9600** or download for free from www.brainbiocentre.com
- Read *Optimum Nutrition for the Mind* by Patrick Holford (Piatkus, £12.99).
Optimum Nutrition for your Child's Mind by Patrick Holford & Deborah Colson (Piatkus, £10.99)
The Alzheimer's Prevention Plan by Patrick Holford & Deborah Colson (Piatkus, £9.99)
To order call **020 8871 2949** or visit www.patrickholford.com

DESCRIPTION OF CONSULTATIONS AND TESTS

Consultations

As soon as we receive your Patient Information Questionnaire we will contact you to make an appointment. The Initial Appointment with your clinical nutritionist (and a Brief Psychiatric Assessment with our psychiatrist if necessary) would involve a review of your health history.

An initial analysis is made and recommendations on tests given. Once test results are available, a 1 hour Follow-up Appointment with the clinical nutritionist will be arranged to explain the test results and to provide dietary and supplement recommendations.

Further Follow-up Appointments with the clinical nutritionist are generally for half an hour, unless

you feel you may need longer to discuss your progress.

A 20 minute Brief Psychiatric Assessment appointment with our psychiatrist may be required prior to the Initial Appointment with the clinical nutritionist. We will advise you about this when booking your appointment. A more extensive Full Psychiatric Assessment appointment (40 minutes) with the psychiatrist is also available to anyone at any time.

In general, most people meet with a clinical nutritionist three to four times over the course of about six months. They may also meet with the doctor once or twice.

Tests

All of these tests are available and the nutritionist will discuss with you which ones are most appropriate for you.

Food Allergies

Quantitative ELISA IgG analysis

Food allergies can contribute to a variety of symptoms and disorders including depression, fatigue, 'brain fog', anxiety, psychosis, ADHD and autism. Two food allergy tests are available:

The FoodScan Indicator Test assesses whether or not there is an IgG antibody response. It does not identify the specific food or foods triggering this response. It is a screening test to determine if the FoodScan 113 test is appropriate.

The FoodScan 113 Test assesses IgG antibody response to 113 commonly eaten foods including grains, dairy products, meats, fish, nuts, vegetables, fruits, herbs and spices.

Neurotransmitter Imbalances

Blood platelet levels of neurotransmitters

This test requires venous blood (i.e. drawn from a vein). Blood will need to be drawn at a private practice in central London. Levels of platelet determinations of serotonin, noradrenalin and plasma acetylcholine are measured. An imbalance in these neurotransmitter levels is principally associated with symptoms of depression and lack of drive.

Histamine Imbalance

Blood plasma

This test requires venous blood (i.e. drawn from a vein). Blood can be drawn at a private practice in central London. An imbalance in histamine is associated with symptoms of schizophrenia and depression.

Mineral Imbalances

Hair mineral analysis

This test requires a small sample of hair (about 2 teaspoons) taken from the back of the head. The hair sample must be untreated (i.e. not dyed or permed) and cut close to the scalp. If scalp hair is not available, then sweat may be used. Deficiencies, excesses or imbalances of minerals including toxic metals may contribute to a variety of symptoms including paranoia, anxiety, aggression, depression, poor memory and concentration.

Homocysteine

Blood plasma

This test requires a sample of blood. Homocysteine is a potentially harmful sulphur bearing amino acid produced in the body. Elevated levels of homocysteine in the blood may be related to Alzheimer's, depression, schizophrenia and autism.

Urinary Peptide Test

Urine samples

An early morning urine sample is collected, frozen and returned to the laboratory. The sample is then tested for chains of amino acids (peptides). Elevated levels of these peptides result from partially undigested milk or gluten foods being absorbed into the blood stream. Most of the peptides are flushed out of the body in the urine but a small proportion will cross into the brain and interfere with function. This often results in the symptoms such as autistic spectrum disorders and learning and behavioural problems.

Comprehensive Stool Analysis

Stool samples

The test kit contains full instructions and all equipment required to perform this test at home, plus self-addressed packaging to return the sample to the laboratory. Two samples must be provided on consecutive days. The Comprehensive Stool Analysis offers a comprehensive view of the health of the gastrointestinal tract, with information about digestion, absorption, bacterial balance, yeast overgrowth, inflammation, metabolic activity, and immune function. Imbalances in any of these areas can produce a variety of symptoms, as gut health may directly or indirectly affect mental health.

Kryptopyrroles

Urinary reagent analysis

This test requires a urine sample. Pyroluria, which is an elevated level of kryptopyrroles in urine, may be a factor in depression, psychosis, anxiety and autism.

Adrenal Stress Index

Saliva samples

Four saliva samples are collected at home over a 24 hour period. The test assesses the body's free-circulating, biologically active hormones of cortisol and DHEA. This shows how well the body is coping with emotional, physical and chemical stresses. Symptoms of anxiety, stress, depression, fears, fatigue, 'brain fog', lack of drive, are associated with imbalances in cortisol and DHEA.

Female Hormone Panel

Saliva samples

This test analyses eleven saliva samples over a 28-day period for the levels of β -estradiol, progesterone, and testosterone. This test may be useful if mental health symptoms are related to hormonal cycle.

Detoxification Capacity Profile

Urine and saliva samples

Saliva samples are collected following the ingestion of a premeasured amount of caffeine, while urine is collected following the ingestion of aspirin and acetaminophen (Paracetamol). The test assesses the body's capacity to detoxify environmental and gut-derived toxins and the body's own hormones and other compounds. This test is useful if it is suspected that the mental health symptoms are related to toxic exposure, hormonal imbalances, gut dysbiosis or a history of drug or alcohol abuse. Associated symptoms may include eczema, joint aches, and mental health symptoms that are worse after eating.

Parasitology

Stool samples

The test kit contains full instructions and all equipment required to perform this test, plus self-addressed packaging to return the sample to the laboratory. Two samples must be provided on consecutive days. Parasitology detects the presence of intestinal parasites including amoebae, flagellates, ciliates, coccidian and microsporidia.

Gut Permeability

Urine samples

This test involves collecting samples before and after consuming a premeasured challenge drink containing lactulose and mannitol. The kit includes full instructions plus challenge drink and collection containers. This test assesses intestinal permeability and absorption levels. Intestinal permeability may lead to increased burden on detoxification systems, the development of food allergies and autoimmune conditions. It has been associated with autism, schizophrenia and psychosis.

FEE SCHEDULE

To see what is included please see our Description of Consultations and Tests information sheet.

Consultations

1 hour Appointment with clinical nutritionist	£160
30 minute Appointment with clinical nutritionist	£90
Brief Psychiatric Assessment	£50
Full Psychiatric Assessment	£190

Tests

FoodScan Indicator	£20
FoodScan IgG 113	£250
Food Intolerance IgE	£120
Hair Mineral Analysis	£55
Kryptopyrroles	£25
Serotonin and Noradrenalin	£170
Histamine	£55
Acetylcholine	£100
Homocysteine	£75
Comprehensive Stool Analysis and Parasitology	£220
Gut Permeability	£90
Detoxification Capacity Profile	£140
Adrenal Stress Index	£90
Female Hormone Panel	£150
Urinary Peptides	£60
Essential Fatty Acids	£100
RBC Magnesium	£25
Vitamin Profile	£100

Payments

A deposit of £50 must be included with each completed Patient Information Questionnaires.

Cancellation fee (if less than 2 working days notice given) is the full consultation fee.

Test fees are payable on ordering.

Consultation fees are payable at the time of the consultation

You have the right to opt out of any tests that you have ordered within 14 days provided that you give written notice and return any home test kits unused. You will receive a full refund less 15% administration charge.

We accept cash, cheques, postal orders and all major credit and debit cards.

Cheques and postal orders should be made payable to the Brain Bio Centre.

Prices are subject to change without notice.

Brain Bio Centre Telephone number: **020 8332 9600**

TERMS AND CONDITIONS

Retain this for your records

1. Payment

- 1.1 A deposit of £50 is required to process an application and make an initial appointment.
- 1.2 Balance of payment for consultations will be payable no later than the day of consultation.
- 1.3 Payment for tests must be made at the time of purchasing/ordering the tests.
- 1.4 A current schedule of all fees can be found in 'Fee Schedule'.

2. Cancellations and Refunds

- 2.1. Cancellations of all booked consultations must be made no later than 2 working days before the consultation.
- 2.2. Cancellations made within 2 working days of scheduled consultation or no shows will be subject to a cancellation fee of charge of the full consultation fee.
- 2.3. Tests that have been arranged and paid for may be cancelled within 14 days. To cancel, give written notice and return the home test kits which must be unopened. Money will be refunded in full less 15% administration charge.

We reserve the right to change our fees without notice.

Your Right to Cancel

Persuant to the Consumer Protection (Distance Selling) Regulations 2000

This notice fulfils the requirement set out in Regulation 7:

- (1) The supplier of the services is the Brain Bio Centre Ltd, Avalon House, 72 Mortlake Road, Richmond, TW9 2JY. Tel: 020 8332 9600 email: info@brainbiocentre.com
- (2) This is a contract for the booking, administration and provision of assessment and remediation services for mental health conditions.
- (3) Delivery or postage may be charged.
- (4) Payment arrangements are set out in the Fee Schedule. You may pay by cheque, cash, or major credit card.

- (5) You have the right to cancel this agreement within 7 working days after the day on which you send your questionnaire to us.
To cancel you must contact us in writing at the address in (1).
- (6) If you have any complaints please contact us in writing at our address set out in (1).
- (7) In addition to your statutory right to cancel out above, you have the contractual right to terminate the contract at any time. But you will remain liable to pay any outstanding fees (including fees for sessions booked but not attended unless they were cancelled giving the notice required in our terms and conditions and returning any unused tests kits).

Data Protection

Information about the patient will be stored by the Brain Bio Centre for the purposes of monitoring the progress of his/her programme. Such information includes personal data relating to the patient's health record and brief details of their family unit. Brain Bio Centre has taken measures to keep such information secure and our policy is not to disclose it to a third party other than those professionals directly involved in the programme. We use other (non-medical) personal information provided by patients and their parents or guardians for the purposes of administration, including collection of money due to use, for which purpose the information may be disclosed to debt collection and tracing agencies.

Returning the Patient Information Questionnaire signed by the patient, or by a parent or guardian if the patient is under 18 years old, constitutes the patient's express written consent to the processing of such data. Any queries regarding the processing of personal data may be directed to the Brain Bio Centre Clinic Manager who is responsible for data protection matters.

PRIVATE AND CONFIDENTIAL

Patient Information

Please provide as much information as possible.

Today's Date _____

PATIENT

Title _____ First Name _____ Last Name _____

Address _____ Post Code _____

Telephone: home _____ mobile/work _____ E-mail _____

Occupation _____ Date of Birth _____ Weight _____ Height _____

Resting Pulse _____ Blood Pressure _____ Blood Type _____ Ethnic Origin _____

Have you been assessed or been to see your doctor or other medical professional for your mental health concern? Yes/ No
 If yes, please give us the name and address and, if possible, telephone number of anyone who is part of your on-going care:
 e.g. your GP, psychiatrist or care co-ordinator or key worker?

Name _____ Role _____ Telephone Number _____

Address _____ Post Code _____

Name _____ Role _____ Telephone Number _____

Address _____ Post Code _____

Name _____ Role _____ Telephone Number _____

Address _____ Post Code _____

DETAILS FOR PARENT(S)/GUARDIAN(S) IF PATIENT IS UNDER 18 YEARS OF AGE

Title _____ First Name _____ Last Name _____

Relationship to Patient _____ Telephone: home _____ mobile/work _____

Address _____ Post Code _____

Title _____ First Name _____ Last Name _____

Relationship to Patient _____ Telephone: home _____ mobile/work _____

Address _____ Post Code _____

TO BE COMPLETED BY ANY PATIENT AGED 18 YEARS AND OVER

Do you have a carer or advocate who you would like to represent you and be present in your consultations? Yes / No

If yes, please give details:

Title _____ First Name _____ Last Name _____

Relationship to Patient _____ Telephone: home _____ mobile/work _____

Address _____ Post Code _____

Patient's Signature _____ Date _____

Your health: What are your primary mental health problems:
(continue on a separate sheet if necessary)

Health problem	Duration	Factors that make it better or worse

List any other health problems you experience:

Health problem	Duration	Factors that make it better or worse

Please list any previous major illnesses _____

Please list any operations you have had _____

Medication

Please mark and provide details for any of the following medications that you are currently being prescribed.

√	Medication	Length of time	Dosage	√	Medication	Length of time	Dosage
	benperidol				chlorpromazine		
	flupentixol				flufenazine		
	haloperidol				levomepromazine		
	pericyazine				perfenazine		
	pimozide				prochloroperazine		
	promazine				solpiride		
	thioridazine				trifluoperazine		
	zuclopenthixol				amisulpride		
	clozapine				olanzapine		
	quetiapine				resperidone		
	sertindole				zotpine		
	flupentixol				fluphenazine		
	haloperidol				pipotiazine		
	risperidone				zuclopenthixol		
	carbamazepine				benzodiazepine		
	valproic acid				lithium		
	ethosuximide				oxcarbamazepine		
	lamotrigene				gabapentin		
	phenobarbitol				levetiracetam		
	phenytoin				primidone		
	topirimate				tiagabin		
	vigabotrin				valproate		
	clonazepam				clobazam		
	fosphenytoin				diazepam		
	paraldehyde				lorazepam		
	amitriptyline				amoxipine		
	clomipramine				dosulepine		
	doxepin				imipramine		
	lofepramine				nortriptyline		
	trimipramine				maprotiline		
	mianserine				trazodone		
	phenelzine				isocarboxazid		
	tranylcypromine				moclobemide		
	citalopram				escitalopram		
	fluoxetine				paroxetine		
	sertraline				flupentixol		
	mirtazapine				reboxetine		
	tryptophan				venlafaxine		

Have you started on an anti-depressant drug or changed medication, in the last six months and noticed any of the following symptoms? Please circle any that you are currently experiencing:

irritability and anger

agitation

excess energy

excitability

restlessness

thoughts of self harm including suicidal thoughts

thoughts of harming others

Are you experiencing side-effects due to your current medication? e.g. tiredness and lack of energy, nausea, headache, feeling dull and heavy, impotence etc. How severe would you consider this, presuming a scale of 1 to 10, where 10 is very severe and 0 is no problem at all? _____

How long have you been on this medication? _____

Have you noticed any change in your symptoms, e.g. improvements, no improvements?

List any other prescribed and over the counter medication and daily dosage.

Have you had a diagnosis of mental illness listed below? Please circle.

schizophrenia

acute and transient psychotic disorders

persistent delusional disorders

schizotypal disorder

other nonorganic psychotic disorders

induced delusional disorder

schizoaffective disorders

unspecified nonorganic psychosis

In the past 2 years have you attempted suicide or had thoughts of self harm? Yes / No

Is there family history relevant to your mental health? _____

It may be necessary to obtain more information. Would you be willing for the Brain Bio Centre's doctor to write to your doctor to obtain this? Yes/ No

Food Diary

Please write down all the foods and drinks consumed over the next 2 days, starting today. Give as much detail as possible including time of consumption, description of the foods, drinks, quantities eaten and brand names. Use a separate sheet if you like.

Day 1

Breakfast

Lunch

Evening Meal

Snacks/drinks

Nutritional Supplements

Do you take any nutritional supplements on a regular basis? Include brand name and daily dosage.

Day 2

Breakfast

Lunch

Evening Meal

Snacks/drinks

Are you consulting any other complementary/alternative therapists? Please name therapy and length of time you have been using it.

Questionnaire

Work your way through the following list of symptoms and tick one of the four response options. Some questions may sound similar to those you have already answered but please still give a response to all questions.

	Never/No	Seldom	Often	Always/Yes
Do you live in a city?	—	—	—	—
Do you spend more than two hours a week in traffic?	—	—	—	—
Have you spent a lot of time in a polluted environment?	—	—	—	—
Do you experience physical or mental fatigue or lethargy?	—	—	—	—
Do you get forgetful or confused?	—	—	—	—
Do you find it hard to think straight?	—	—	—	—
Do you have frequent mood swings?	—	—	—	—
Do you find it hard to deal with stress?	—	—	—	—
Are you often depressed?	—	—	—	—
Do you get deep depressions for no particular reason?	—	—	—	—
Do you suffer with post-menopausal depression?	—	—	—	—
Do you get suicidal thoughts?	—	—	—	—
Do you suffer from anxiety or irritability?	—	—	—	—
Do you have aggressive outbursts or crying spells?	—	—	—	—
Do you get hyperactive?	—	—	—	—
Do you have difficulty sleeping or insomnia?	—	—	—	—
Do you suffer from nervousness?	—	—	—	—
Were you shy or over-sensitive as a child?	—	—	—	—
Do you ever feel 'unreal'?	—	—	—	—
Do you ever 'hear' your own thoughts?	—	—	—	—
Do you see or hear things abnormally?	—	—	—	—
Are you naturally suspicious of people?	—	—	—	—
Do you have abnormal fears, compulsions or rituals?	—	—	—	—
Do you suffer with delusions or illusions?	—	—	—	—
Do you suffer with manic depression?	—	—	—	—
Do you have schizophrenia?	—	—	—	—
Do you have extreme fears or paranoia?	—	—	—	—
Do you have violent or impulsive behaviour?	—	—	—	—
Do have inner tension or 'driven' feeling?	—	—	—	—
Do you suffer with phobias?	—	—	—	—
Do you get angry or aggressive feelings?	—	—	—	—
Do you suffer with emotional instability?	—	—	—	—
Do you have obsessive or compulsive tendencies?	—	—	—	—
Do you grind your teeth?	—	—	—	—
Are you restless?	—	—	—	—
Are you frequently tired?	—	—	—	—
Are you socially withdrawn?	—	—	—	—
Are your mental health symptoms often worse after eating?	—	—	—	—
Do you have difficulty concentrating?	—	—	—	—
Do you have dyslexia or learning difficulties?	—	—	—	—
Is your memory declining or are you becoming forgetful?	—	—	—	—

	Never/No	Seldom	Often	Always/Yes
Do you have a short attention span?	—	—	—	—
Is your stamina, or ability to keep going, noticeably decreasing?	—	—	—	—
Do you have a lack of drive or motivation?	—	—	—	—
Do you rarely initiate or complete tasks?	—	—	—	—
Do you have difficulty visualising?	—	—	—	—
Do you have difficulty learning new things?	—	—	—	—
Do you get facial puffiness, circles or discolouration around the eyes?	—	—	—	—
Do you have dry or rough skin and/or hair?	—	—	—	—
Do you have stretch marks?	—	—	—	—
Do you suffer from dry hair, hair loss or dandruff?	—	—	—	—
Do you have pale skin that burns easily?	—	—	—	—
Do you get excessively thirsty?	—	—	—	—
Do you sometimes feel weak?	—	—	—	—
Do you feel drowsy after meals?	—	—	—	—
Do you have white spots on your fingernails?	—	—	—	—
Is your eyesight deteriorating?	—	—	—	—
Is your mental clarity or concentration decreasing?	—	—	—	—
Are you intolerant to the cold or have cold hands and feet?	—	—	—	—
Do you suffer from sore throats or nasal congestion?	—	—	—	—
Do you get frequent colds and infections?	—	—	—	—
Do you have constipation, gas, bloating or indigestion?	—	—	—	—
Did you have loose bowels or skin problems at onset of mental health problems?	—	—	—	—
Do you suffer with nausea?	—	—	—	—
Do you gain weight easily?	—	—	—	—
Do you get muscle pain or tension?	—	—	—	—
Do you get joint pain?	—	—	—	—
Do you have a good pain tolerance?	—	—	—	—
Do you get headaches or migraines?	—	—	—	—
Do have difficult orgasm with sex?	—	—	—	—
Do you have easy orgasm with sex?	—	—	—	—
Do you suffer with PMS, painful periods or breast pain?	—	—	—	—
Do you have irregular menstruation?	—	—	—	—
Are you impotent?	—	—	—	—
Are you a light sleeper?	—	—	—	—
Do you dream infrequently?	—	—	—	—
Do you have poor dream recall?	—	—	—	—
Do you sneeze in sunlight?	—	—	—	—
Do you cry, salivate or feel nauseated easily?	—	—	—	—
Do you have a tendency to be overweight?	—	—	—	—
Are you having a hard time keeping your weight stable?	—	—	—	—
Do you have a fast metabolism?	—	—	—	—
Do you produce a lot of body heat?	—	—	—	—
Do you have crowded upper front teeth?	—	—	—	—
Do you have little body hair and a lean build?	—	—	—	—

	Never/No	Seldom	Often	Always/Yes
Do you have large ears or long fingers and toes?	—	—	—	—
Do you have a good tolerance of alcohol?	—	—	—	—
Do you get seasonal allergies (e.g. hay fever)?	—	—	—	—
Do you have an alcohol or drug use problem?.....	—	—	—	—
Do you have a poor tolerance of alcohol or drugs?	—	—	—	—
Are you sensitive to pain (low pain threshold)?	—	—	—	—
Do you have raised blood pressure?	—	—	—	—
Do you have rapid or irregular heart beat?	—	—	—	—
Do you have a dry mouth?	—	—	—	—
Do you suffer from palpitations or blackouts?	—	—	—	—
Do you ever experience dizziness, trembling or fainting?	—	—	—	—
Do you get excessive or night sweats?	—	—	—	—
Do you have a history of colic, eczema, asthma, rashes or ear infections?	—	—	—	—
Do you suffer from frequent, rapid colds or a blocked nose?	—	—	—	—
Do you have watery, itchy eyes, red eyelids or dark circles under the eyes?	—	—	—	—
Do you have itchy ears, frequent ear infections or ringing in the ears?	—	—	—	—
Do you have excessive mucus, a stuffy nose or sinus problems?	—	—	—	—
Do you suffer with excess sweating and strong body odour?	—	—	—	—
Do you suffer with indigestion or bloating?	—	—	—	—
Do you get constipation or diarrhoea?	—	—	—	—
Do you need a coffee, tea or cigarette to get you going in the morning?	—	—	—	—
Do you get cravings for sweets or stimulants (including coffee, tea, cigarettes)?	—	—	—	—
Would you find it hard to give up tea, coffee or cola?	—	—	—	—
Do you add sugar to tea/coffee and/or eat lots of sweet foods?	—	—	—	—
Do you have headaches or shaky feelings that are relieved by sugar, caffeine or cigarettes?	—	—	—	—
Do you smoke more than five cigarettes or half a cannabis joint a day?	—	—	—	—
Do you need an alcoholic drink most days?	—	—	—	—
Do you drink alcohol or take recreational drugs on your own?	—	—	—	—
Do you regularly take recreational drugs (i.e. twice a month or more)?	—	—	—	—
Are you addicted to amphetamines, cocaine or caffeine tablets (e.g. Pro-Plus)?	—	—	—	—
Do you take heroin?	—	—	—	—
Have you taken 'broad spectrum' antibiotics?	—	—	—	—
Have you taken tetracycline or other broad-spectrum antibiotics for one month or longer?	—	—	—	—
Are your symptoms worse on damp, muggy days or in mouldy places?	—	—	—	—
Do you crave sugar?	—	—	—	—
Do you have a feeling of being 'drained'?	—	—	—	—
Do you experience burning, itching or discharge from your vagina/penis?	—	—	—	—
Do your eyes burn, itch or tear?	—	—	—	—
QUESTIONS FOR WOMEN ONLY				
Have you had any hormonal treatment? (e.g., contraceptive, HRT)	—	—	—	—
Have you experienced fertility problems or had a miscarriage?	—	—	—	—
Are you post menopausal?	—	—	—	—
Are many of your symptoms related to your menstrual cycle?	—	—	—	—

TERMS AND CONDITIONS

1. Payment

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- 1.4 A current schedule of all fees can be found in 'Fee Schedule'.

2. Cancellations and Refunds

- 2.1 Cancellations of all booked appointments must be made no later than 2 working days before the appointment.
- 2.2 Cancellations made within 2 working days of scheduled appointment or no shows will be subject to a cancellation charge of the full consultation fee.
- 2.3 Tests that have been arranged and paid for may be cancelled within 14 days. To cancel, give written notice and return the test kits which must be unopened. Money will be refunded in full less 15% administration charge.

We reserve the right to change our fees.

Your Right to Cancel

Pursuant to the Consumer Protection (Distance Selling) Regulations 2000. This notice fulfils the requirement set out in Regulation 7:

- (1) The supplier of the services is Brain Bio Centre, Avalon House, 72 Lower Mortlake Road, Richmond, TW9 2JY, Tel: 020 8332 9600.
email: info@brainbiocentre.com
- (2) This is a contract for the booking, administration and provision of assessment and remediation services for mental health conditions.
- (3) Delivery or postage may be charged.
- (4) Payment arrangements are set out in the 'Fee Schedule'. You may pay by cheque, cash, or major credit card.
- (5) You have the right to cancel this agreement within 7 working days after the day on which you receive the information. To cancel, you must contact us in writing at our address as set out in (1).
- (6) If you have any complaints please contact us in writing at our address as set out in (1).

- (7) In addition to your statutory right to cancel as set out above, you have the contractual right to terminate the contract at any time. But you will remain liable to pay any outstanding fees (including fees for sessions booked but not attended unless they were cancelled giving the notice required as outlined in our terms and conditions and returning any unused tests kits).

Data Protection

Information about the patient will be stored by the Brain Bio Centre for the purposes of monitoring the progress of his/her programme. Such information includes personal data relating to the patient's health record and brief details of their family unit. Brain Bio Centre has taken measures to keep such information secure and our policy is not to disclose it to a third party other than those professionals directly involved in the programme. We use other (non-medical) personal information provided by patients and their parents or guardians for the purposes of administration, including collection of money due to use, for which purpose the information may be disclosed to debt collection and tracing agencies.

Returning the Patient Information form signed by the patient, or by a parent or guardian if the patient is under 18 years old, constitutes the patient's express written consent to the processing of such data. Any queries regarding the processing of personal data may be directed to the Brain Bio Centre Clinic Manager at the Brain Bio Centre who is responsible for data protection matters.

PATIENT TO SIGN HERE

I have read and agree to the terms and conditions outlined above.

Signed.....

Date.....

If patient is under 18 years of age, this form must be signed by a parent or guardian.

Deposit Form

Patient s Name _____ Date of Birth _____

Please indicate your payment method below and supply credit/debit card details if paying by this method. **Do not send cash through the post.**

Note: cash is an acceptable form of payment when attending the clinic in person.

Payment by Cheque

Please enclose a cheque for £50 made payable to the Brain Bio Centre and enclose with your completed forms

Payment by Credit/Debit Card

Please complete the details below. The Brain Bio Centre will process a payment of £50 against this card.

Type of card: MasterCard / Visa / Switch / American Express (please circle one)

Card number _____

Start date _____ Expiry date _____ Issue number (if applicable) _____

Name on Card _____

Signature _____

PRIVATE AND CONFIDENTIAL

Patient Information for babies and children aged 0-10 years

Please provide as much information as possible.

Today's Date _____

Child's First Name _____ Last Name _____ Date of Birth _____

Address _____

_____ Post Code _____

Home Tel No _____ Parent Tel No _____

Mobile _____ Contact Email of Parent _____

Gender (M/F) _____ Child's / Baby's Age _____ years _____ months

Resting Pulse _____ Blood Pressure _____ Blood Type _____

Main reason for visit: _____

GP Details

GP Name: _____

Address: _____

_____ Telephone No: _____

Is your GP aware that you are consulting a nutritional consultant? **Yes/No**

Are you happy for your GP to be kept informed on the progress of your child? **Yes/No**

Any other health professionals involved in your child's care: _____

Address: _____ Telephone No: _____

Family Details

Mother Name: _____ Age: _____

Health problems: _____ Are you the birth mother? **Yes/No**

Father Name: _____ Age: _____

Health problems: _____ Are you the genetic father? **Yes/No**

Others/sisters:

Male/Female Age: _____ Health problems: _____

Male/Female Age: _____ Health problems: _____

Male/Female Age: _____ Health problems: _____

Male/Female Age: _____ Health problems: _____

Family History

Please read through the following list of medical conditions and tick the appropriate box corresponding to whether family members have a history of suffering from the listed medical conditions.

Medical History	Father	Mother	Sibling(s)	Maternal Grand mother	Maternal Grand father	Paternal Grand mother	Paternal Grand father	Other
Allergy to milk								
Allergy to wheat								
Other allergy								
Arthritis								
Asthma								
Crohn's disease								
Coeliac disease								
Diabetes								
Ear infections recurrent								
Eczema								
Other skin complaint								
Fungal infection								
Heart disease								
High blood pressure								
Hives								
Irritable bowel syndrome								
Migraines								
Malabsorption								
Phenylketonuria								
Stroke								
Anorexia								
Autism								
Asperger's syndrome								
Bulimia								
Depression								
Downs syndrome								
Dyslexia								
Hyperactivity								
Learning difficulties								
Schizophrenia								
Speech delay								
Tendency to be a loner								
Night blindness								

Home Life:

Who lives at home with your child? _____

Does your child attend? (Please tick) Day Nursery Child minder Playgroup School/Special School

Occupation of Mother _____ Occupation of Father _____

Do you have any pets at home? **Yes/No** If yes, please list: _____

Pollution Profile

Does your child live in a city or by a busy road? **Yes/No**

Does your child live in a smoky atmosphere? **Yes/No**

Does your child usually drink filtered or bottled water? **Yes/No**

Does your child eat non-organic food? **Yes/No**

Is the main house near to: pylons, mobile phone mast, factory, petrol station, agricultural land, flight path (please underline)

Does your child have a computer or TV in their bedroom? **Yes/No**

Does your child have a mobile phone, which is used regularly? **Yes/No**

Pregnancy Details:

Were there any particular difficulties during the pregnancy? **Yes/No**

If yes, please list _____

Birth Details:

Was this your first labour? **Yes/No**

Duration of pregnancy (normal gestation is 40 weeks) _____

Were there any particular difficulties relating to the birth? **Yes/No**

If yes, please list _____

APGAR score _____

Did the baby suffer (please tick) jaundice oxygen deficit any other problems _____

Did the baby require special care? **Yes/No** Why/duration _____

Additional information about labour/birth: _____

Child's Health Profile

Please circle all that apply now, and underline all that previously applied

Miscellaneous symptoms

- | | | |
|---------------------|----------------------------|---------------------|
| Earache | Poor Co-ordination | Obsessive Behaviour |
| Catarrh | Head banging/Rocking | Mood Swings |
| Colic | Sensitivity to Noise | Thrush |
| Excessive crying | Phobias | Night Terrors |
| Aggression | Shows no Fear | Disturbed Sleep |
| Constant Runny Nose | Recurrent chest infections | |
| Snoring | Threadworms | |

Specific Disorders

- | | | |
|---|--------------------|---------------------|
| Asthma | ADD/ADHD | Down's Syndrome |
| Eczema/Dermatitis/Autism/Autism Spectrum Disorder | Aspergers Syndrome | Cleft Palate |
| Hayfever | Epilepsy | Heart Disease |
| Food Allergies | Crohn's Disease | Sickle Cell Anaemia |
| Dyslexia | Phenylketonuria | Diabetes |
| Dyspraxia | AIDS | Haemophilia |
| Cerebral palsy | | Cancer |

Child's Personality/Behaviour

- | | | | |
|------------------------|-----------------------|----------------------|----------------|
| Nervous | Irritable | Contented | Popular |
| Plays well with others | Unhappy | A 'Holy Terror' | Very 'Good' |
| Easily Distracted | Sociable | Temper Tantrums | Restless |
| Wide-Awake | Learning Difficulties | Tip Toes | Impulsive |
| Tough | Tidy | 'Gifted' Child | Affectionate |
| Excitable | Emotional | Messy | Lazy/Lethargic |
| Rejects Affection | Nail Biter | 'All Over the Place' | Clumsy |
| Sleepy | Agile | | |

Medical History

How many courses of antibiotics has the child taken over the past 3 years? (Please tick)

- none 1-3 courses 4-9 courses more than 10 courses

Does/has your take/taken any other prescribed medications? **Yes/No**

If yes, please give age, illness and treatment _____

Does your child take over the counter medications? **Yes/No**

If yes, which and what for? _____

Has your child ever been referred to a specialist? **Yes/No**

If yes, please give age, reason and type of specialist: _____

What tests has your child had done by GP, specialist, other? _____

Has your child received medical diagnosis of any condition? **Yes/No**

If yes, please expand (e.g. Asthma, Coeliac Disease, Anaemia) _____

Have you sought 'alternative health care advice for your child e.g. Homeopath, Cranial Osteopath **Yes/No**

If yes, please state which: _____

Does your child have a history of contracting any viral infections? Tick all that apply

- none encephalitis meningitis chicken pox measles
 mumps rubella unknown viral infection
 other, please specify _____

Does your child have a history of epilepsy or seizures? **Yes / No**

If yes, please specify type of epilepsy, date of diagnosis and date of last episode: _____

Does your child have a history of bacterial or fungal infections? Tick all that apply.

- none oral thrush genital thrush athletes foot impetigo
 other, please specify _____

Does your child have any history of the following problems with their ears? Tick all that apply.

- none hearing loss persistent ear infection redness of ears use of grommets/tubes
 other, please specify _____

Does your child have any history of the following problems with their eyes? Tick all that apply.

- none loss of sight dark rings around the eyes squint
 other, please specify _____

Additional medical information? _____

List any previous major illnesses _____

List any operations that the child has had _____

Immunisation Programme

Has your child received the recommended standard immunisations? **Yes/No**

If no, please detail those given and those excluded and why: _____

Has your child ever had an adverse reaction to any vaccine? **Yes/No**

If yes, please specify _____

Does your child suffer from frequent colds, coughs infections? **Yes/No**

Does your child have eczema, asthma, hayfever, arthritis? Please underline which

Does your child suffer from food sensitivity? **Yes/No**

Have you noticed any adverse reactions in your child after eating certain foods? **Yes/No**

If yes, state which foods and what reactions _____

Development History

Has your GP or any other medical practitioner ever expressed concern regarding your child's development? **Yes/No**

If yes, please expand e.g. speech, learning, walking etc _____

Have there been any hearing problems? **Yes/No**

Has your child's growth been 'normal' e.g. Height, Weight, Growth Centile **Yes/No**

If no, please detail _____

Digestive Profile – please circle as appropriate

Does your child chew food well? **Yes/No** Does your child suffer from bad breath? **Yes/No**

Does your child suffer tummy upsets? **Yes/No** Does your child suffer with an itchy bottom? **Yes/No**

Does your child have a daily bowel movement? **Yes/No** Does your child suffer from diarrhoea? **Yes/No**

Does your child suffer from constipation? **Yes/No** Does your child suffer from bloating/excessive wind **Yes/No**

Are the stools normal, pale, offensive, floating (please underline which)

Does your child have a history of bowel problems?

no yes don't know

Is your child fully bowel continent (i.e. not using a nappy at all during the day or night)?

no yes don't know

Type of bowel problem. Tick all that apply

diarrhoea constipation alternating diarrhoea/constipation undigested food in stools

blood in stools mucus in stools loose stools

other, please specify _____

How long have the bowel symptoms been present? Tick one box only.

0-3 months 4-6 months 7-12 months more than a year

How many bowel movements does your child have in the average week (over the past 3 months)? Tick one box only.

none 1 bowel movement per week 2 bowel movements per week 3 bowel movements per week

4 bowel movements per week 5-15 bowel movements per week more than 1 per week

Please describe the normal consistency / type of stool your child produces from the items shown below. Tick all that apply.

separate hard lumps (nut-like) sausage shaped and lumpy

sausage shaped with cracked surface sausage shaped or snake-like smooth and soft

fluffy pieces with ragged edges and mushy soft blobs but with clear-cut edges

watery with no solids frothy stools

large bulky stools

other, please specify _____

Does your child ever require any manual manoeuvres to help with defecation? Tick all that apply.

none digital evacuation (use of hands) support of the pelvic floor

other, please specify _____

Please describe the general colour of the stools produced. Tick all that apply.

light brown dark brown black yellow, sand coloured green

other colour, please specify _____

Does your child ever present with any of the following problems? Tick all that apply.

bloating distension (pot belly) indications of pain on passing stools indications of abdominal pain

flatulence (frequent passing of wind) none

Does your child have any problems with restricted eating habits based on either taste or texture?

no yes don't know

If yes, which types of food / drink?

milk other dairy products (yoghurts, cheese) bread

pasta cereals (eg Weetabix)

other, please specify _____

Are there any foods that your child is not permitted to have in their diet?

none yes (specify from options below)

casein-free diet gluten-free diet vegetarian

other, please specify _____

Does your child show any signs of having an excessive thirst?

no

yes, (specify types of drink and average amount per day) _____

Additional Information

Is there any other information relevant to the child's medical history that you feel is of relevance? e.g. contact with hazardous substances. Other events related to symptom onset.

Nutritional Information – Child's Feeding History

Did you bottle feed at all? **Yes/No** From what age? _____ Which formula? _____

Which, if any, special formula were required e.g. soya, casein free? _____

How old was your baby when your started weaning onto solids? _____

Which foods were introduced and in what order?

1. _____ Any Reactions _____ Age _____

2. _____ Any Reactions _____ Age _____

3. _____ Any Reactions _____ Age _____

Current Eating Habits

Would you describe our child's appetite as: (please tick) good medium poor

Is your child a fussy eater? **Yes/No**

Is your child currently following a specific dietary regime e.g. gluten free? Please describe _____

Are there any foods that your child craves? Please describe _____

Are there any foods that your child dislikes intensely? Please describe _____

Do you go out of your way to avoid giving foods containing preservatives and additives? **Yes/No**

Do you avoid giving foods that contain sugar? **Yes/No**

How many cans of fizzy drinks does your child drink in a week? _____

How many times a week does your child have meals containing fried or fast foods (e.g. fish fingers, McDonalds) _____

How many portions daily of fruit and vegetables does your child have? _____

How many slices of bread or rolls does your child eat in a week? _____

Do you normally eat white or wholemeal rice, pasta and flour? _____

Does your child eat at nursery or at school? **Yes/No**

If yes, please describe this food/drink _____

Does your child take a 'lunch box' to school **Yes/No**

What nutritional supplements does your child take on a daily basis? _____

Food Diary

Write down the daily food and drink consumption of the child for 2 representative days. Give as much detail as possible including description of the foods, drinks, quantities eaten and brand names.

Day 1	Day 2
Breakfast	Breakfast
_____	_____
Lunch	Lunch
_____	_____
Evening Meal	Evening Meal
_____	_____
Snacks and Drinks	Snacks and Drinks
_____	_____

Activity Profile:

How much time per day does your child watch TV? _____

How much time per day does your child use a computer (including school and home)? _____

How much exercise does your child have in a week? _____

What sport does your child play? _____

Any activities, hobbies or clubs (e.g. dancing) _____

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PATIENT TO SIGN HERE

I have read and agree to the terms and conditions outlined above.

Signed.....

Date.....

If patient is under 18 years of age, this form must be signed by a parent or guardian.

Deposit Form

Patient s Name _____ Date of Birth _____

Please indicate your payment method below and supply credit/debit card details if paying by this method. **Do not send cash through the post.**

Note: cash is an acceptable form of payment when attending the clinic in person.

Payment by Cheque

Please enclose a cheque for £50 made payable to the Brain Bio Centre and enclose with your completed forms

Payment by Credit/Debit Card

Please complete the details below. The Brain Bio Centre will process a payment of £50 against this card.

Type of card: MasterCard / Visa / Switch / American Express (please circle one)

Card number _____

Start date _____ Expiry date _____ Issue number (if applicable) _____

Name on Card _____

Signature _____