PATIENT INFORMATION				❑ ***New Patient*** ❑ ***Established PT***
FIRST NAME:	MIDDLE:	LAST:		Social Security #:
Date of Birth: / /	Sex: ❑ M ❑ F	Marital status (circle one) Single / Mar / Div / Sep / Wid	Employment Status (circle one) Employed / Retired / Student / Unemployed	Employer Name:
Your Address:	City:		State:	Zip Code:
Race: ❑Decline ❑White ❑American Indian /Alaska Nat. ❑Asian ❑Black/African American ❑Nat.Hawaii/Oth Pac Islander ❑Other: _____	Ethnic Group: ❑Non-Hispanic ❑Hispanic/Latino ❑Decline		Language: ❑English ❑Spanish ❑Other: _____	
Primary Phone#: ❑ Cell ❑ Work ❑Home ( )	Alternate Phone#: ❑ Cell ❑ Work ❑Home ( )		Email Address: Appointment reminder by email? ❑ Yes ❑ No	
Referring Physician:	How did you hear about our office?			
Primary Physician:	Reason for visit:		Date of Injury/Onset: / /	

RESPONSIBLE PARTY:		
Person Financially Responsible [Guarantor] ❑ Self Only→Skip to insurance section ❑ Other Guarantor→Complete this section	Guarantor's Full Name:	Patient's Relationship to Guarantor: ❑ Child ❑ Spouse ❑ Other:
Address (if different):	Date of Birth: / /	Social Security #:

INSURANCE INFORMATION:			
Primary Insurance Company Name:	Plan Name:	Type of Plan: ❑ PPO ❑ POS ❑ HMO ❑ Medicaid ❑ Medicare ❑Tricare ❑ Medicare HMO ❑ WC ❑ Lien	
Claims Address:			Phone#: ( )
Policy#:	Group #:	Group Name:	
COPAY: $	Annual Deductible: $ ❑ Met ❑ Not Met ❑ Don't Know	Coinsurance: ❑ None (Plan pays 100%) ❑ 80/20 ❑ 90/10 ❑ 70/10 ❑ Don't Know	Effective Date: / /
Is plan thru employer? ❑ No ❑ Yes	Employer Name & Address:		Occupation:
Secondary Insurance Company Name:	Plan Name:	Type of Plan: ❑ Medicare Supplemental ❑ Medicaid ❑ Other Employer/Commercial ❑ Spouse's Plan (Pls. complete guarantor section) ❑ Other:	
Claims Address:			Phone#: ( )
Policy#:	Group #:	Group Name:	
Is plan thru employer? ❑ No ❑ Yes	Employer Name & Address:		

ACKNOWLEDGEMENT:

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to Dallas Neuropsychology, PLLC as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.

Patient/Guardian signature: _____ Date _____

Dallas Neuropsychology, PLLC

Financial Policy

Effective March 2020 Patient Name:_____

Thank you for choosing DALLAS NEUROPSYCHOLOGY, PLLC as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. _____ I understand that if I do not have my insurance card, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. _____ I understand that DALLAS NEUROPSYCHOLOGY, PLLC will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and DALLAS NEUROPSYCHOLOGY, PLLC. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.

3. _____ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

4. _____ I understand that if I am unable to make a scheduled appointment, I need to contact DALLAS NEUROPSYCHOLOGY, PLLC at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. MISSED APPOINTMENTS AND/OR APPOINTMENTS NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE WITH THE PROVIDERS BELOW WILL BE ASSESSED THE FOLLOWING FEES: DR. BUCHANAN- $100; DR. SANDI BROWNE- $50; SPEECH THERAPY- $75

5. _____ I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

6. _____ DALLAS NEUROPSYCHOLOGY, PLLC will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify DALLAS NEUROPSYCHOLOGY, PLLC if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

7. _____ FORMS: I understand an appointment must be scheduled with my provider for any forms or paperwork to be completed. If I choose not to schedule an appointment, I am required remit payment at the time of the request at the self-pay rate of $150/hr.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

Signature of Responsible Party:_____ Date:_____

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: DALLAS NEUROPSYCHOLOGY, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party:_____ Date:_____

Notice of Dallas Neuropsychology's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations Dallas Neuropsychology may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions: "PHI" refers to information in your health record that could identify you. "Treatment, Payment and Health Care Operations" – Treatment is when your doctor or provider provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your doctor or provider consults with another health care provider, such as your family physician or another psychologist, psychiatrist or counselor. - Payment is when your doctor or provider obtains reimbursement for your healthcare. Examples of payment are when Dallas Neuropsychology discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. - Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination. "Use" applies only to activities within Dallas Neuropsychology such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. "Disclosure" applies to activities outside of Dallas Neuropsychology, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization Your doctor or provider may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when your doctor or provider is asked for information for purposes outside of treatment, payment and health care operations, your doctor or provider will obtain an authorization from you before releasing this information. Your doctor or provider will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes your doctor or provider has made about your conversation during a private, group, joint, or family counseling session, which your doctor or provider has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) your doctor or provider has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization Your doctor or provider may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If your doctor or provider has cause to believe that a child has been, or may be, abused, neglected, or sexually abused, a report of such must be made within 48 hours to the

Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.

- Adult and Domestic Abuse: If your doctor or provider has cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, an immediate report of such must be made to the Department of Protective and Regulatory Services.
- Health Oversight: If a complaint is filed against your doctor or provider with the State Board of Examiners of Psychologists, the State Board of Medical Examiners or the State Board of Licensed Professional Counselors, they have the authority to subpoena confidential mental health information from your doctor or provider relevant to that complaint.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and your doctor or provider will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety: If your doctor or provider determines that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, your doctor or provider may disclose relevant confidential mental health information to medical or law enforcement personnel.
- Worker's Compensation: If you file a worker's compensation claim, your doctor or provider may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Your Doctor's or Provider's Duties Patient's Rights:

Right to Request Restrictions –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, your doctor or provider is not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a doctor or provider at Dallas Neuropsychology. Upon your request, Dallas Neuropsychology will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in the mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your doctor or provider may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, your doctor or provider will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your doctor or provider may deny your request. At your request, your doctor or provider will discuss with you the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, your doctor or provider will discuss with you the details of the accounting process.

Right to a Paper Copy – You have the right to obtain a paper copy of this notice from Dallas Neuropsychology upon request, even if you have agreed to receive the notice electronically.

Doctor's or Provider's Duties:

Your doctor or provider is required by law to maintain the privacy of PHI and to provide you with a notice of the legal duties and privacy practices with respect to PHI.

Dallas Neuropsychology reserves the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, your doctor or provider is required to abide by the terms currently in effect.

If Dallas Neuropsychology revises these policies and procedures, you will be notified that changes have been made. You may then access the changes on Dallas Neuropsychology website or a paper copy of the changes will be provided at your request.

V. Complaints If you are concerned that your doctor or provider has violated your privacy rights, or you disagree with a decision made about access to your records, you may contact the office manager of Dallas Neuropsychology for further information.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Dallas Neuropsychology office manager can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy This notice will go into effect on April 14, 2003.

Dallas Neuropsychology reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that Dallas Neuropsychology maintains. If Dallas Neuropsychology revises these policies and procedures, you will be notified that changes have been made in person, by telephone, by mail or by email. You may then access the changes on Dallas Neuropsychology website or a paper copy of the changes will be provided at your request.

_____ _____

Patient Name (PRINT) Date of Birth

_____ _____

Patient Signature Date

INFORMED CONSENT FOR TELEHEALTH SERVICES

Definition of Telehealth

Telehealth involves the use of electronic communications to enable Dallas Neuropsychology, PLLC's providers to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Dallas Neuropsychology, PLLC utilizes secure, encrypted audio/video transmission software to deliver telehealth.

4. I understand that if my provider believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a health professional associated with any form of treatment/assessment, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.

5. I understand the alternatives to treatment/assessment through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my provider, I may be directed to "face-to-face" treatment/assessment.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.

8. I understand that my express consent is required to forward my personally identifiable information to a third party.

INFORMED CONSENT FOR TELEHEALTH SERVICES

9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based treatment/assessment services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services

Dallas Neuropsychology, PLLC will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, the self-pay rate will apply. We will provide you with a statement of service to submit to your insurance company if you wish.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my provider, and all of my questions have been answered to my satisfaction.

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____

Patient/Guardian Name (PRINT)

_____ _____

Patient/Guardian Signature Date

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize my health care provider at Dallas Neuropsychology, PLLC to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):
(please include name, address, phone number, and relationship to patient)

_____

_____

_____

Purpose: I authorize the release of my health information for the purpose of:
_____facilitating consultation and/or collaboration
_____facilitating family involvement in treatment
_____other: _____

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information the provider has in her possession, including information relating to any medical history, mental or physical condition, and any treatment received by Dallas Neuropsychology, PLLC.

Term: I understand that this Authorization will remain in effect:
- ❑ Until the Provider fulfills this request.

Redisclosure: I understand my health care provider cannot guarantee the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary.

_____ _____
Patient name (PRINT) Date of Birth

_____ _____
Patient/Guardian Signature Date

Dr. B. Buchanan, PhD – Clinical Psychologist/Neuropsychologist

Neuropsychological Exam Intake Form

For us to be able to fully evaluate you, we request you complete the following intake forms *completely*, to the best of your ability. We realize there is a lot of information, but every question is important. Please get assistance from a family member or person who knows you well, if necessary, to complete the forms accurately.

Name: _____ Date: _____

Date of Birth: _____ Age:_____

Dominant hand **(circle one)**: Right Left Ambidextrous

Emergency Contact: _____ Phone #: _____

This form completed by: ☐ Self ☐ Other: _____

Reason for Evaluation: _____

PREVIOUS/CURENT MEDICAL HISTORY:

Heart/Vascular/Stroke:

☐ Hypertension (High Blood Pressure) ☐ Hyperlipidemia (High Cholesterol) ☐ Stroke / CVA
☐ Congestive Heart Failure ☐ Arrythmia (ex: Atrial fibrillation) ☐ TIA
☐ Myocardial Infarction (Heart attack) ☐ Angioplasty / Stents ☐ Pacemaker

Lung Disease:

☐ COPD ☐ Asthma ☐ On Oxygen

Gastrointestinal Disease:

☐ History of gastrointestinal bleed ☐ Chronic Constipation ☐ Chronic Diarrhea
☐ Irritable Bowel Syndrome ☐ Gastroesophageal Reflux Disease (GERD)
☐ Ischemic Colitis ☐ Crohn's Disease

Endocrine:

☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism

Neurological:

☐ Parkinson's disease ☐ Seizure Disorder ☐ Multiple Sclerosis ☐ Neuropathy
☐ Past Head Injury ☐ Tremor ☐ Migraines

Kidney and Liver:

☐ Renal Insufficiency ☐ Hepatitis ☐ Cirrhosis

Ear / Nose / Eye:

☐ Hearing Loss ☐ Seasonal Allergies ☐ Macular degeneration
☐ Glaucoma ☐ Cataract(s)

Other:

☐ Cancer (list types) _____
☐ Chronic Pain (list areas) _____
☐ Arthritis If yes, ☐ Rheumatoid ☐ Osteoarthritis
☐ Other Pertinent Health History: _____

Previous Surgeries or Hospitalizations:

_____

_____

Toxic exposures (pesticides, heavy metals, paints, solvents)? ☐ **Yes** ☐ **No**

Have you had any of the following completed? (check all that apply)

☐ Brain scan (MRI or CT scan) ☐ X-ray (Head or Spine) ☐ Ultrasound ☐ Spinal Tap

☐ EEG ☐ EMG ☐ FMRI ☐ PET scan ☐ SPECT

Neurological Office Exam (name of neurologist/hospital) _____

Current Medications: (or attach a list)

Medication, Supplements, or OTC	Dose	Date started	Is it beneficial? Circle one	List any side effects
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	

Psychiatric History: *Have you ever….*

Had any with mental health problems? ☐ Yes ☐ No Diagnosis? _____

Been hospitalized for psychiatric care? ☐ Yes ☐ No When? _____

Attempted suicide? ☐ Yes ☐ No If so, when? _____

Had counseling or therapy? ☐ Yes ☐ No Dates:_____ Was it helpful? ☐ Yes ☐ No

Do you hear or see things others do not? ☐ Yes ☐ No Describe: _____

Sleep Behavior (check all that apply): ☐ sleepwalking ☐ nightmares ☐ recurrent dreams

☐ difficulty falling asleep ☐ wake up during the night ☐ difficulty getting up ☐ no problems

Time you lay down to sleep_____ PM Fall asleep_____ PM Wake up_____ AM

Average number of hours you sleep a night _____

How many times do you wake up during the night?_____

Are you able to fall back to sleep easily? ☐ Yes ☐ No

Do you feel rested when you wake up? ☐ Yes ☐ No

Do you take naps during the day? ☐ Yes ☐ No

Do you have sleep apnea? ☐ Yes ☐ No If so, when diagnosed?_____

Do you use a CPAP/BiPAP? ☐ Yes ☐ No

Appetite:

Any changes in appetite or weight? ☐ Increased ☐ Decreased ☐ No change

Glasses of water per day_____ Number of meals per day _____ Snacks per day _____

Caffeinated beverages per day _____ (tea/coffee/soda/energy drinks)

Alcohol, Tobacco and Drug History:

Alcohol: Current Use (Last 30 days): ☐ Yes ☐ No How Much: _____

Past Use: ☐ Yes ☐ No If yes, when did you quit? _____ Length of Use: _____

Tobacco: Current Use (Last 30 days): ☐ Yes ☐ No How Much: _____

Past Use: ☐ Yes ☐ No If yes, when did you quit? _____ Length of Use: _____

Drugs: Current Use (Last 30 days): ☐ Yes ☐ No How Much: _____

Past Use: ☐ Yes ☐ No If yes, when did you quit? _____ Length of Use: _____

Ethnic/Cultural/Language/ Social Background:

Primary Language: _____

Marital Status: _____

Who do you live with?_____

Children (names/ages): _____

Who do you consider your social support?_____

Activities of Daily Living:

Do you drive? ☐ Yes ☐ No Did you drive today? ☐ Yes ☐ No

Remembering to Take/Refill Medications: ☐ **Independent** ☐ **Dependent on** _____

Managing Finances/Paying Bills: ☐ **Independent** ☐ **Dependent on** _____

Shopping/Community Outings: ☐ **Independent** ☐ **Dependent on** _____

Recreation/Exercise: (type/how often) _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Unemployed

Current Occupation: _____ Length of employment:_____

Former Occupation(s):_____

Hobbies: _____

Education History: Last grade *completed* _____ Average grades _____

Earned: ☐ GED ☐ HS diploma ☐ Some college ☐ Associate's ☐ Bachelor's ☐ Master's ☐ Doctorate

Name of College/University: _____ Major: _____

While in school: (check all that apply)

☐ Received accommodations through Special Education; Details:_____

☐ Diagnosed with learning disability; Details: _____

☐ Had behavioral problems; Details: _____

☐ Problems with learning or attention in school; Details: _____

☐ Academic problems in college; Details: _____

Military History: ☐ Yes ☐ No Branch:_____ Date of discharge:_____

Medical Records

Have you received services at any of the following medical facilities? (check all that apply)

- ☐ Hunt Regional Medical Center (hospital / partners)
- ☐ Baylor Scott & White; location: _____
- ☐ Texas Health Hospital
- ☐ UT Southwestern
- ☐ Parkland
- ☐ Other: _____

I voluntarily consent to and authorize my health care provider, Dr. B. Buchanan, PhD, to access and use my health information from the providers indicated above to assist in facilitating consultation and/or collaboration.

_____ _____

Patient Name (PRINT) DOB

_____ _____

Patient/Guardian Signature Date

REVIEW OF SYSTEMS

Place an X or check mark next to symptoms experienced **RECENTLY**

GENERAL		URINARY	
Loss of Appetite		Urinary Frequency	
Loss of Weight		Incontinence	
Fever		Urinary Tract Infection	
Fatigue		SLEEP	
EYE/EAR/NOSE/THROAT		Insomnia	
Vision Loss		Daytime Sedation / Frequent Naps	
Hearing Loss		NEUROLOGICAL	
Difficulty Swallowing		Headache	
Sinus or Allergy Symptoms		Numbness / Pain in Feet	
CARDIOVASCULAR		Weakness	
Chest Pain		Falls	
Palpitations / Irregular Heartbeat		Syncope (Passing Out)	
Shortness of Breath		Trouble Walking	
RESPIRATORY		Tremor	
Cough		Change in Handwriting	
Wheezing		PSYCHIATRIC	
Bronchitis		Depression	
Pneumonia		Apathy / Disinterest	
GASTROINTESTINAL		Anxiety	
Reflux		Irritability	
Abdominal Pain		Suspiciousness / Paranoia	
Constipation		Hallucinations	
Diarrhea			
Nausea / Vomiting			

PATIENT COMPETENCY RATING (SELF FORM)

Name: _____ Date: _____

How much problem do I have in:	Can't Do	Very difficult To do	Can do with some difficulty	Fairly Easy to do	Can do easily
1. Preparing my own meals?	1	2	3	4	5
2. Dressing myself?	1	2	3	4	5
3. Taking care of my personal hygiene?	1	2	3	4	5
4. Washing dishes?	1	2	3	4	5
5. Doing the laundry?	1	2	3	4	5
6. Taking care of my finances?	1	2	3	4	5
7. Keeping appointments on time?	1	2	3	4	5
8. Starting conversation in a group?	1	2	3	4	5
9. Staying involved in work activities?	1	2	3	4	5
10. Remembering what I had for dinner last night?	1	2	3	4	5
11. Remembering names of people I see often?	1	2	3	4	5
12. Remembering my daily schedule?	1	2	3	4	5
13. Remembering important things I must do?	1	2	3	4	5
14. Driving a car if I had to?	1	2	3	4	5
15. Getting help when I am confused?	1	2	3	4	5
16. Adjusting to unexpected changes?	1	2	3	4	5
17. Handling arguments with people I know well?	1	2	3	4	5
18. Accepting criticism from other people?	1	2	3	4	5
19. Controlling crying?	1	2	3	4	5
20. Acting appropriately when I'm around friends?	1	2	3	4	5

PATIENT COMPETENCY RATING (SELF FORM)

Name: _____ Date: _____

	Can't Do	Very difficult To do	Can do with some difficulty	Fairly Easy to do	Can do easily
21. Showing affection to people?	1	2	3	4	5
22. Participating in group activities?	1	2	3	4	5
23. Recognizing when something I say or do has upset someone else?	1	2	3	4	5
24. Scheduling daily activities?	1	2	3	4	5
25. Understanding new instructions?	1	2	3	4	5
26. Consistently meeting my daily responsibilities?	1	2	3	4	5
27. Controlling my temper when something upsets me?	1	2	3	4	5
28. Keeping from being depressed?	1	2	3	4	5
29. Keeping my emotions from affecting my ability to go about the days activities?	1	2	3	4	5
30. Controlling my laughter?	1	2	3	4	5
31. Remaining awake & alert all day?	1	2	3	4	5
32. Paying attention and concentrating on what I have to do?	1	2	3	4	5
33. Thinking things through before doing them?	1	2	3	4	5
34. Working at a fast pace?	1	2	3	4	5
35. Keeping myself looking nice?	1	2	3	4	5
36. Keeping friends?	1	2	3	4	5
37. Developing or keeping good relationships with members of the opposite sex?	1	2	3	4	5
38. Finding interesting things to do with my spare time?	1	2	3	4	5

PLEASE CHECK TO MAKE SURE YOU ANSWERED ALL QUESTIONS

DASS 21

NAME _____ DATE _____

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Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all - NEVER

1 Applied to me to some degree, or some of the time - SOMETIMES

2 Applied to me to a considerable degree, or a good part of time - OFTEN

3 Applied to me very much, or most of the time - ALMOST ALWAYS

		N	S	O	AA	FOR OFFICE USE D	A	S
1	I found it hard to wind down	0	1	2	3			
2	I was aware of dryness of my mouth	0	1	2	3			
3	I couldn't seem to experience any positive feeling at all	0	1	2	3			
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3			
5	I found it difficult to work up the initiative to do things	0	1	2	3			
6	I tended to over-react to situations	0	1	2	3			
7	I experienced trembling (eg, in the hands)	0	1	2	3			
8	I felt that I was using a lot of nervous energy	0	1	2	3			
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3			
10	I felt that I had nothing to look forward to	0	1	2	3			
11	I found myself getting agitated	0	1	2	3			
12	I found it difficult to relax	0	1	2	3			
13	I felt down-hearted and blue	0	1	2	3			
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3			
15	I felt I was close to panic	0	1	2	3			
16	I was unable to become enthusiastic about anything	0	1	2	3			
17	I felt I wasn't worth much as a person	0	1	2	3			
18	I felt that I was rather touchy	0	1	2	3			
19	I was aware of the action of my heart in the absence of physicalexertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3			
20	I felt scared without any good reason	0	1	2	3			
21	I felt that life was meaningless	0	1	2	3			
	TOTALS							

PATIENT COMPETENCY RATING (RELATIVE'S FORM)

Patient's Name: _____

Patient: Age: ___ Education: ____ Sex: ___Male __Female Handed: R L : Ethnicity: _____

Informant's relationship to patient (circle one):

1. Mother	5. Sister	9. Aunt	13. Niece	17. Nurse
2. Father	6. Brother	10. Uncle	14. Nephew	18. Other
3. Wife	7. Grandmother	11. Son	15. Cousin	
4. Husband	8. Grandfather	12. Daughter	16. Friend_____	

Informant: Age: ___ Education: ____ Sex: ___Male __Female Handed: R L : Ethnicity: _____

How well is informant acquainted with patient's behavior?

1. Hardly at all
2. Not so well
3. Fairly well
4. Pretty well
5. Very well

Instructions: The following is a questionnaire that asks you to judge this person's ability to do a variety of very practical skills. Some of the questions may not apply directly to things they do often, but you are asked to complete each question as if it were something they "had to do". On each question, you should judge how easy or difficult a particular activity is for them and circle the appropriate number. PLEASE ANSWER ALL QUESTIONS.

	Can't do	Very difficult to do	Can do with some difficulty	Fairly easy to do	Can do easily
How much problem does he/she have in:					
1. Preparing their own meals?	1	2	3	4	5
2. Dressing themselves?	1	2	3	4	5
3. Taking care of their personal hygiene?	1	2	3	4	5
4. Washing dishes?	1	2	3	4	5
5. Doing the laundry?	1	2	3	4	5
6. Taking care of their finances?	1	2	3	4	5

PATIENT COMPETENCY RATING (RELATIVE'S FORM)

Name: _____ Date: _____

	Can't do	Very difficult to do	Can do with some difficulty	Fairly easy to do	Can do easily
7. Keeping appointments on time?	1	2	3	4	5
8. Starting conversation in a group?	1	2	3	4	5
9. Staying involved in work activities?	1	2	3	4	5
10. Remembering what they had for dinner last night?	1	2	3	4	5
11. Remembering names of people they see often?	1	2	3	4	5
12. Remembering their daily schedule?	1	2	3	4	5
13. Remembering important things they must do?	1	2	3	4	5
14. Driving a car if they had to?	1	2	3	4	5
15. Getting help when they're confused?	1	2	3	4	5
16. Adjusting to unexpected changes?	1	2	3	4	5
17. Handling arguments with people they know well?	1	2	3	4	5
18. Accepting criticism from other people?	1	2	3	4	5
19. Controlling crying?	1	2	3	4	5
20. Acting appropriately when they're around friends?	1	2	3	4	5
21. Showing affection to people?	1	2	3	4	5
22. Participating in group activities?	1	2	3	4	5
23. Recognizing when something they say or do has upset someone else?	1	2	3	4	5

PATIENT COMPETENCY RATING (RELATIVE'S FORM)

Name: _____ Date: _____

	Can't do	Very difficult to do	Can do with some difficulty	Fairly easy to do	Can do easily
24. Scheduling daily activities?	1	2	3	4	5
25. Understanding new instructions?	1	2	3	4	5
26. Consistently meeting their daily responsibilities?	1	2	3	4	5
27. Controlling their temper when something upsets them?	1	2	3	4	5
28. Keeping from being depressed?	1	2	3	4	5
29. Keeping their emotions from affecting their ability to go about the day's activities?	1	2	3	4	5
30. Controlling their laughter?	1	2	3	4	5
31. Remaining awake and alert all day?	1	2	3	4	5
32. Paying attention and concentrating on what they are doing?	1	2	3	4	5
33. Thinking things through before doing them?	1	2	3	4	5
34. Working at a fast pace?	1	2	3	4	5
35. Keeping themselves looking nice?	1	2	3	4	5
36. Keeping friends?	1	2	3	4	5
37. Developing or keeping good relationships with members of the opposite sex?	1	2	3	4	5
38. Finding interesting things to do with their spare time?	1	2	3	4	5

PLEASE CHECK TO MAKE SURE YOU ANSWERED EACH QUESTION. DO NOT LEAVE ANY QUESTIONS BLANK.