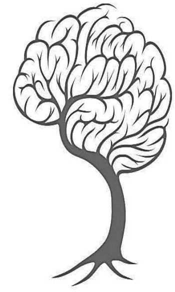
R e n j a n R. M a t h e w, P h. D.
DFW Neuropsychology Consultants LLC
600 E John Carpenter Fwy, Suite 291 Irving, TX 75062
TEL 469-444-3226 FAX 469-208-0240
www.dfwneuropsychology.com
email: neuropsychclinic@outlook.com



**PATIENT INFORMATION:**

Name:________________________________________

Address:______________________________________

City:_______________ State:__________ Zip Code:____________

Phone Numbers: Home:_______________ Cell:__________________

Email:______________________________ ☐ Male ☐ Female

Date of Birth:______________ Age:______ Marital Status:______________

SSN:_________________________________________

**RESPONSIBLE PARTY (STATEMENTS WILL BE SENT TO):**

Name:________________________________________

Address:______________________________________

City:_______________ State:__________ Zip Code:____________

Phone Numbers: Home_______________ Cell:__________________

Email:________________________________________

Date of Birth:______________ Age:______ Marital Status______________

Relationship to the patient:______________________________

**PRIMARY INSURANCE INFORMATION:**

Insurance Company:____________________ Phone No:____________

Subscriber's Name:__________________________________

Subscriber's ID:__________ Group No:__________ Date of Birth:__________

Employer:______________________________________

**SECONDARY INSURANCE INFORMATION:**

Insurance Company:____________________ Phone No:____________

Subscriber's Name:__________________________________

Subscriber's ID:________________ Group No:________________

**WHO REFERRED YOU FOR THE CONSULT:**

Physician's Name:__________________________________

Tel:__________________ Fax:____________________

Email:________________________________________

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# CONSENT FOR SERVICES

**NAME** ____________________________________________

**DOB** ____________________________ **DATE** ____________________

**INSURANCE INFORMATION – HIPPA – COPAY - FINANCIAL RESPONSIBILITY**
***(Please check √ or initial all the following and sign on the bottom of the page)***

_____FINANCIAL RESPONSIBILITY: I, the undersigned, accept financial responsibility for payment of all fees at the time of the visit unless other arrangements have been made.

_____AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any information regarding my/my child's condition or treatment to my insurance company and the referral sources.

_____AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.

_____HIPPA NOTICE: I, the undersigned, acknowledge that I have read the HIPPA notice form Psychologist-Patient Services Agreement and agree to its terms and serves described in the agreement.

**SIGNATURE** ____________________________________________
*(Patient, or parent if the patient is a minor)*

# Renjan R. Mathew, Ph. D.

## Neuropsychological Intake Form

**Notice to Patient:** This personal history form is intended to help us gather all the information we need to help you. Everything is confidential and will not be released without your permission. Don't worry if you can't answer some of the questions or if some do not apply to you. Just fill in the blanks as completely as you can, and we will review the information with you during the initial consultation. PLEASE PRINT OR WRITE LEGIBLY. Thank you.

Today's Date:________________________

Name:______________________________________________________________

(*First*) (*Middle Initial*) (*Last*)

Date of Birth:____________________ Age:__________ Gender: ☐Female ☐Male

Writing hand: ☐Right ☐Left ☐Ambidextrous Ethnicity:________________________

Highest Level of Education:____________________________________________

Is English your first language? ☐Yes ☐No If not, what is your first language?______________

Who referred you for this evaluation?____________________________________

Have you ever had neuropsychological or psychological testing before? ☐Yes ☐No

If yes, by whom?________________ When?______________ Why?____________

### HISTORY OF PRESENTING PROBLEM

Why are you being seen for a neuropsychological evaluation (e.g. I had a stroke, I got in a car accident and sustained a head injury; Family members say I have memory problems; etc.)?________________

______________________________________________________________

Date problem(s) began (estimate):____________________________________

Course: ☐Getting Better ☐Getting Worse ☐Staying the Same

### CURRENT PROBLEMS

**Please check ALL Categories that apply.** Each Category has samples to assist you in your selection.

| ☐**Attention** | |
|---|---|
| ☐ Frequently missing details, making careless errors | ☐ Difficulty paying attention for long periods of time |
| ☐ Easily distracted | ☐ Difficulty following instructions |

| ☐ **Processing speed** | |
|---|---|
| ☐ Difficulty thinking quickly | ☐ Feeling as though most people talk too fast |
| ☐ Taking longer to complete tasks than before | ☐ Frequently asking people to repeat themselves (not due to hearing difficulty) |

| ☐ Learning and Memory | |
|---|---|
| ☐ Difficulty remembering recent events, names, faces, the date, etc. | ☐ Difficulty learning and remembering new information |
| ☐ Loss of long-term memories | ☐ Forgetting to take medication |

| ☐ Executive Functioning | |
|---|---|
| ☐ Acting before thinking | ☐ Difficulty problem solving or making bad decisions |
| ☐ Difficulty following multi-step direction | ☐ Difficulty planning and organizing |

| ☐ Nonverbal/visual spatial skills | |
|---|---|
| ☐ Getting lost in familiar locations | ☐ Problems Driving |
| ☐ Inappropriate use of objects (i.e. remote as hat) | ☐ Right-Left or directional disorientation |

| ☐ Speech & Language | |
|---|---|
| ☐ The feeling that a word is on the tip of your tongue | ☐ Mislabeling items (ex. Clock vs. watch) |
| ☐ Reduced speech volume | ☐ Difficulty understanding others or following conversations |

| ☐ Motor/Coordination | |
|---|---|
| ☐ Difficulty buttoning a shirt | ☐ Difficulty opening medicine bottles |
| ☐ Difficulty with walking or balance/ recent falls | ☐ Shakiness/Tremor |

| ☐ Sensory | |
|---|---|
| ☐ Reduced sense of smell | ☐ Tingling sensation |
| ☐ Loss of feeling in part of your body | ☐ Difficulty perceiving your bodies location in space |

| ☐ Physical Problems | |
|---|---|
| ☐ Frequent headaches | ☐ Bowel or Bladder Incontinence |
| ☐ Dizziness, nausea, vomiting | ☐ Shortness of Breath |
| ☐ Sleep Disturbance/ Weight Change | ☐ Pain |

| ☐ Mood & Behavior | |
|---|---|
| ☐ Increased irritability | ☐ Hallucinations (visual, auditory, or olfactory) |
| ☐ Increased Sadness/ Crying for unknown reasons | ☐ Increase nervousness, suspiciousness, etc. |
| ☐ Thoughts of harming yourself or taking your life | ☐ Discomfort in Social Situations |

| ☐ Recent Life Stressors | |
|---|---|
| ☐ Change in job | ☐ Change in marital status |
| ☐ Death of loved one | ☐ Financial or legal problem |
| ☐ Moved to a new location | ☐ Taking care of an aging or ill loved one |

Please rate your overall stress level: ◻ Very Low ◻ Low ◻ Average ◻ High ◻ Very High

What is the greatest source of your stress at this time?____________________________________________

## ACTIVITIES OF DAILY LIVING

Do you drive? □ Yes □ No
Who does the cooking at home? □ Myself □ Another Person
Do you manage your own finances? □ Yes □ No
Do you manage your own medications? □ Yes □ No

## MEDICAL HISTORY

Please check the box to indicate any problems you have been identified as having and note (estimate) the year of diagnosis.

| Neurologic | Date | Endocrine | Date |
|---|---|---|---|
| □ Brain Injury | | □ Diabetes | |
| □ Brain Aneurysm | | □ Hypoglycemia | |
| □ Migraines | | □ Hypothyroidism | |
| □ Movement Disorder | | □ Hyperthyroidism (e.g., Graves) | |
| □ Brain or Spinal Tumor | | □ Parathyroid Disorder | |
| □ Stroke | | □ Adrenal Gland Disorder (e.g., Addisons) | |
| □ Seizures | | □ Kidney Disorder | |
| □ Dementia | | □ Cushing's Syndrome | |
| □ Narcolepsy | | □ Low Testosterone | |
| □ Sleep Disorder | | □ Menopause | |
| **Cardiovascular** | **Date** | **Ear, Nose, & Throat** | **Date** |
| □ High Blood Pressure | | □ Dizziness (e.g., vertigo, BPPV) | |
| □ High Cholesterol | | □ Chronic Ear Infections | |
| □ Heart Disease | | □ Swallowing Disorder | |
| □ Arteriosclerosis | | □ Macular Degeneration | |
| □ Blood Disease (e.g., anemia) | | □ Cataracts or Glaucoma | |
| **Genital-Urinary/ Gastro-Intestinal** | **Date** | **Muscular-Skeletal** | **Date** |
| □ Bowel or Bladder Incontinence | | □ Amputation | |
| □ Colon Disease (e.g., Crohn's, IBS) | | □ Arthritis | |
| □ Regular Urinary Tract Infections | | □ Degenerative Joint Disease | |
| □ Gastroesophageal Reflux Disease | | □ Osteoporosis | |
| □ Pancreatitis | | □ Fibromyalgia | |
| □ Liver Disease (e.g., hepatitis) | | □ Chronic Fatigue Syndrome | |
| **Oncology** | **Date** | **Genetic** | **Date** |
| □ Type & Site of cancer:____________ ______________________________ | | □ Type (e.g., Fragile X, Down Syndrome, Mitochondrial Disease)______________ | |
| **Mental Health** | **Date** | **Other** | **Date** |
| □ Anxiety Disorder | | | |
| □ Mood Disorder (e.g., Depression, Bipolar) | | | |
| □ Psychotic Disorder (e.g., Schizophrenia) | | | |
| □ Substance Use Disorder | | | |

Have you had any blood work or imaging (e.g., CT, MRI, X-Ray) done in the past year? □ Yes □ No

If yes, what did you have done:_____________________________________________________________

Please list ALL medications you are currently taking

| Medication | Dose | How often do you take it | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you EVER received treatment for depression, anxiety, or any other emotional difficulty? Check all that apply:

- ◻ Never received mental health treatment
- ◻ Outpatient counseling
- ◻ Inpatient psychiatric services
- ◻ Pharmacological treatment (antidepressants, anti-anxiety medications, etc.)

Are you CURRENTLY receiving treatment for depression, anxiety, or other emotional difficulty? ◻Yes ◻No

## FAMILY MEDICAL HISTORY

Please check any diagnoses that your family members (blood relatives) have.

| Medical Condition | Mother | Father | Mother's Mother | Mother's Father | Father's Father | Father's Mother | Sibling | Other |
|---|---|---|---|---|---|---|---|---|
| Dementia | | | | | | | | |
| Seizures | | | | | | | | |
| Movement Disorder (e.g., Parkinson's) | | | | | | | | |
| Multiple Sclerosis | | | | | | | | |
| Migraines | | | | | | | | |
| Stroke | | | | | | | | |
| Diabetes | | | | | | | | |
| Hypertension | | | | | | | | |
| Cancer | | | | | | | | |
| Hyper-/hypothyroidism | | | | | | | | |
| Genetic Disorder | | | | | | | | |
| Learning Disability | | | | | | | | |
| ADHD | | | | | | | | |
| Mental Retardation | | | | | | | | |
| Other:________________________ | | | | | | | | |

## SOCIAL HISTORY

Where were you born?______________________________________________

Relationship Status: □ Single □ Married (Years Married:__________) □ Divorced □Widowed □ Other

Do you have Children: □ Yes □ No If yes, please list their ages:________________________

Currently living in: □ House □ Condo/Apartment □Assisted Living Facility □ Nursing Home

## OCCUPATIONAL/EDUCATION HISTORY

| Level of Education | Name of School/Degree | Year Graduated | Typical Grades or GPA |
|---|---|---|---|
| High School | | | |
| College or Vocational | | | |
| Graduate School | | | |
| Other | | | |

Did you have any academic difficulty? □ Yes □ No

If yes, please answer the next 2 questions.

1. Did you repeat a grade? □ Yes □ No
2. Were you diagnosed with a learning Disability? □ Yes □ No

Employment Status: □ Employed □ Unemployed □ Retired □ Disabled If

you are currently employed, please answer the next 3 questions.

1. Where do you work?______________________________________________
2. How long have you worked there?_____________ 3. What's your Job title?_________________________

Did you serve in the Military? □ Yes □ No

If yes, Branch:_________________________ Years Served:_________________ MOS:______________________

Discharge Rank:_______ Type of Discharge:____________________

Deployment History:______________________________________________

## SUBSTANCE USE

<table>
<tr><td>Tobacco Use</td><td colspan="2">□ Never used □ Currently use □ Quit (When did you quit?_____________)</td><td>Type and amount per day:</td></tr>
<tr><td rowspan="2">Alcohol Use</td><td>□ Past<br>□ Present<br>□ Never</td><td>How often: □ Occasional/Rare □ Weekly □ Daily</td><td>Estimated # of drinks per week:_________</td></tr>
<tr><td colspan="3">Are you or others you know concerned about your alcohol use? □ Yes □ No<br>Have you ever received treatment for alcoholism or alcohol abuse? □ Yes □ No<br>If yes, please list the date(s) and location(s) of your treatment:</td></tr>
<tr><td>Recreational Drug Use (Includes prescription drug abuse)</td><td>□ Past<br>□ Present<br>□ Never</td><td colspan="2">Have you ever received treatment for drug abuse or addiction? □ Yes □ No<br>If yes, please list the date(s) and location(s) of your treatment:</td></tr>
<tr><td>Caffeine Use</td><td>□ Past<br>□ Present<br>□ Never</td><td colspan="2">Estimated number of 8-oz. cups of caffeinated beverages per day: ______</td></tr>
</table>

## LEGAL HISTORY

Do you have any legal history (prior court cases, arrests, etc.)? If yes, please describe:______________________

______________________________________________________________________________

Is this case involved in litigation, or do you intend to pursue litigation in the future? □ Yes □ No

Have you granted anyone Power of Attorney (POA)? □ Yes □ No If so, who?____________________

# AUTHORIZATION TO OBTAIN/RELEASE CONFIDENTIAL RECORDS AND INFORMATION

When completed and signed by you, this form authorizes me to release/obtain protected information from your clinical record to the person you designate.

I authorize Dr. Renjan R. Mathew, Ph.D./DFW Neuropsychology, to obtain/release the following:

Please describe the information that you want to be disclosed:

☐ Results of psychological/neuropsychological evaluation
☐ Medical history and evaluation(s), and treatment information
☐ Reports of diagnostic/imaging study (MRI/CT/PET/EEG etc.)
☐ Progress notes and treatment summary
☐ Educational records
☐ Other ______________________________________________________________

______________________________________________________________________

This information should be obtained from/released to the following:

1. ☐ OBTAIN/ ☐ RELEASE Person/ Facility: ______________________________

Address: ______________________________________________________________

Phone: ___________________________ Fax _________________________________

2. ☐ OBTAIN/ ☐ RELEASE Person/ Facility: ______________________________

Address: ______________________________________________________________

Phone: ___________________________ Fax _________________________________

All available pertinent records or specific to the time between date ______________and ________________.

It has been explained to me, and I fully understand this request/authorization to release/obtain records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed or upon fulfillment of the purposes stated above.

Patient Name (Printed): ____________________________________________DOB__________________

Patient Signature (parent/guardian if patient is a minor): ________________________________________

Date: ________________________________________________________________________________

# COVID-19 Health Questionnaire

***Please help us keep everyone safe and not spread the COVID-19 virus.***

**This form is required to be completed just before your doctor's visit. Please do not upload the Health Questionnaire but bring this with you.**

**Name:** ____________________________________

**Phone Number:** ______________________________

**Please answer the following questions:** **Today's Date:** ____________ **Time:** _______ **Temperature:** ________

| | | |
|---|---|---|
| Have you experienced any of the following symptoms in the past 48 hours:<br>• fever or chills<br>• cough<br>• shortness of breath or difficulty breathing<br>• fatigue<br>• muscle or body aches<br>• headache<br>• new loss of taste or smell<br>• sore throat<br>• congestion or runny nose<br>• nausea or vomiting<br>• diarrhea | ☐ Yes | ☐ No |

| | | |
|---|---|---|
| Have you been in close physical contact in the last 14 days with:<br>• Anyone who is known to have laboratory-confirmed COVID-19?<br>OR<br>• Anyone who has any symptoms consistent with COVID-19? | ☐ Yes | ☐ No |

| | | |
|---|---|---|
| Are you isolating or quarantining because you may have been exposed to a person with COVID-19, or are you worried that you may be sick with COVID-19?<br>OR<br>Are you currently waiting on the results of a COVID-19 test? | ☐ Yes | ☐ No |

| | | |
|---|---|---|
| Have you traveled in the past ten days?<br>Travel is defined as any trip that is overnight AND on public transportation (plane, train, bus, Uber, Lyft, cab, etc.) OR any trip that is overnight AND with people who are not in your household | ☐ Yes | ☐ No |

| STOP |
|---|
| If you have answered YES to any of the above questions or have any of the above symptoms, please **do not enter the consultation room/office** and notify us immediately. We will be rescheduling your appointment without any charges. |

| | | |
|---|---|---|
| Are you Fully Vaccinated (Received the final dosage of COVID vaccine 14 days before your appointment date)? | ☐ Yes | ☐ No |

Signature____________________________________________________________