# Neuropsychology Consult Intake

email: neuropsychclinic@outlook.com

NEUROPSYCHOLOGY
DFW CONSULTANTS

Renjan R. Mathew, Ph.D.

**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:_____

NEUROPSYCHOLOGY
DFW CONSULTANTS

**Renjan R. Mathew, Ph.D.**
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TEL 469-444-3226 FAX 469-208-0240
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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)***

_____ CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by DFW Neuropsychology/Renjan R. Mathew, Ph.D., employees, and such associates, assistants, and other health care providers, as my treating provider deems necessary. Such services may include diagnostic procedures, examinations, and treatment. I acknowledge that no warranty or guarantee regarding the results or cure has been made to me.

_____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)*

NEUROPSYCHOLOGY DFW CONSULTANTS

# 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?_____

**A list of questions about your health is given below. Think carefully and check every problem that applies to you. If you are unsure what the question means or not sure of your answer, please draw a circle around the question, and the doctor will help you with it later. Make sure to answer every question.**

*Have you had…*

1. __loss of sense of smell
2. __change in the sense of smell
3. __smell of bad odors
4. __loss of sense of taste
5. __change in the sense of taste
6. __bad tastes

*Are you...*

7. __blind in the left eye
8. __blind in the right eye
9. __blind in both eyes

*Do you*

10. __wear glasses
11. __wear contact lenses

*Have you had...*

12. __blurred vision
13. __double vision
14. __loss of vision
15. __blank spots in vision
16. __flashing lights in vision

*Are you*

17. __deaf in the left ear
18. __deaf in the right ear
19. __deaf in both ears

*Do you*

20. __wear a hearing aid

*Have you had...*

21. __loss of hearing
22. __ringing in the ears
23. __strange sounds in the ears

*Have you had...*

24. __any paralysis
25. __muscle weakness
26. __muscle twitching
27. __muscle spasms
28. __trouble walking
29. __coordination problems
30. __balance problems
31. __tremors or shakiness
32. __problems with dropping things

*Have you had...*

33. __numbness
34. __"tingling" skin
35. __" pins and needles."
36. __burning skin
37. __loss of feeling
38. __loss of telling hot from cold
39. __change in skin

*Do you have...*

40. __pain
41. __headaches

*Have you had...*

42. __black-out spells
43. __seizures or fits
44. __fainting spells
45. __periods where you "lose" time

*Do you..*

46. __get lost often
47. __forget where you are
48. __forget time and day
49. __forget meetings
50. __have memory problems

*Do you...*

51. __hear unusual sounds
52. __see unusual things
53. __have strange feelings

*Does it seem that you...*

54. __can't think as quickly as before
55. __find it hard to think clearly
56. __are more easily distracted
57. __can't concentrate
58. __have trouble with "common sense."

*Have you had trouble*

59. __using tools
60. __telling right from left
61. __getting dressed
62. __remembering the right word when talking
63. __understanding others
64. __following conversation
65. __with your speech
66. __with reading
67. __with writing

*Have you had problems with...*

68. __sadness or depression
69. __stress, tension, or anxiety
70. __anger or keeping your temper
71. __worry or guilt
72. __change in your attitudes
73. __loss of interest

*Have you had...*

74. __childhood diseases or injuries
75. __head injuries
76. __problems with nerves
77. __high fevers
78. __serious infections
79. __diabetes
80. __liver problems
81. __kidney problems
82. __problems with arteries
83. __a stroke
84. __hypertension
85. __heart problems
86. __blood problems
87. __cancer

*Have you had...*

88. __surgery

If yes-for what_____
_____

If there are any symptoms or medical problems that you have not been asked about here, please describe below: _____
_____
_____
_____
_____
_____
_____

If there are any other concerns that you would like to address in the neuropsychological evaluation, please mention here:_____
_____
_____
_____
_____
_____

*Thank you for completing this form*

## Neurobehavioral Screen

Patient's name: _____ Date: _____

Informant's name: _____ Relationship: _____

The items below reflect possible **changes** in the patient from their old, usual self.
Check the appropriate box to indicate if there has been a change in any of these areas or not, and add any comments (eg, mild, moderate, severe).

| | No Change | Change | Comment |
|---|---|---|---|
| **Cognitive** | | | |
| Difficulty remembering recent or upcoming events | ☐ | ☐ | |
| Getting lost or not knowing where they are | ☐ | ☐ | |
| Difficulty keeping track of time | ☐ | ☐ | |
| Difficulty finding appropriate words | ☐ | ☐ | |
| Difficulty making decisions or problem-solving | ☐ | ☐ | |
| **Functional Activities** | | | |
| Difficulty writing checks, paying bills, etc. | ☐ | ☐ | |
| Difficulty driving a car | ☐ | ☐ | |
| Difficulty shopping alone | ☐ | ☐ | |
| Difficulty performing household tasks | ☐ | ☐ | |
| Difficulty pursuing hobbies and leisure activities | ☐ | ☐ | |
| **Social Activities** | | | |
| Difficulty holding a conversation | ☐ | ☐ | |
| Decreased social activity with family or friends | ☐ | ☐ | |
| Less cooperative, more difficult to get along with | ☐ | ☐ | |
| Less aware of how others feel, hurtful | ☐ | ☐ | |
| Less concerned about dressing or grooming | ☐ | ☐ | |
| **Behavioral** | | | |
| Sad, depressed | ☐ | ☐ | |
| Anxious, worried | ☐ | ☐ | |
| Impatient, fidgety | ☐ | ☐ | |
| Less interested in hobbies or social activities | ☐ | ☐ | |
| Acts impulsively, disinhibited | ☐ | ☐ | |
| Increased or decreased appetite, weight change | ☐ | ☐ | |
| Increased or decreased sleep, daytime fatigue | ☐ | ☐ | |

**FIGURE 1-5** Neurobehavioral screen.

# PHQ-9 Depression Scale

| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | NOT AT ALL | SEVERAL DAYS | MORE THAN HALF THE DAYS | NEARLY EVERY DAY |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | ○ 0 | ○ 1 | ○ 2 | ○ 3 |
| 2. Feeling down, depressed, or hopeless | ○ 0 | ○ 1 | ○ 2 | ○ 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | ○ 0 | ○ 1 | ○ 2 | ○ 3 |
| 4. Feeling tired or having little energy | ○ 0 | ○ 1 | ○ 2 | ○ 3 |
| 5. Poor appetite or overeating | ○ 0 | ○ 1 | ○ 2 | ○ 3 |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down | ○ 0 | ○ 1 | ○ 2 | ○ 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | ○ 0 | ○ 1 | ○ 2 | ○ 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | ○ 0 | ○ 1 | ○ 2 | ○ 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way | ○ 0 | ○ 1 | ○ 2 | ○ 3 |

10. If you checked off any problems on this questionnaire so far, how difficult have these problems made if for you to do your work, take care of things at home, or get along with other people?

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ○ 0 | ○ 1 | ○ 2 | ○ 3 |

# Functional Activities Questionnaire

**Administration:** Ask the informant to rate the patient's ability using the following scoring system:

- Dependent = 3
- Requires assistance = 2
- Has difficulty but does by self = 1
- Normal = 0
- Never did [the activity] but could do now = 0
- Never did and would have difficulty now = 1

| | |
|---|---|
| Writing checks, paying bills, balancing checkbook | |
| Assembling tax records, business affairs, or papers | |
| Shopping alone for clothes, household necessities, or groceries | |
| Playing a game of skill, working on a hobby | |
| Heating water, making a cup of coffee, turning off stove after use | |
| Preparing a balanced meal | |
| Keeping track of current events | |
| Paying attention to, understanding, discussing TV, book, magazine | |
| Remembering appointments, family occasions, holidays, medications | |
| Traveling out of neighborhood, driving, arranging to take buses | |
| **TOTAL SCORE:** | |

**Evaluation:** Sum scores (range 0-30). Cutpoint of 9 (dependent in 3 or more activities) is recommended to indicate impaired function and possible cognitive impairment.

# COVID-19 Health Questionnaire

| | | |
|---|---|---|
| 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 |
| **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. | | |

## AUTHORIZATION TO OBTAIN/RELEASE CONFIDENTIAL RECORDS AND INFORMATION

NEUROPSYCHOLOGY DFW CONSULTANTS

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: _____

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