DALLAS
P: 214-620-5580 F: 469.264.5037 — NEUROPSYCHOLOGY — dallasneuropsychology.com

You have been referred to Dallas Neuropsychology, PLLC, the office of Dr. Buchanan, for a neuropsychological evaluation.

*NOTE: IF YOU HAVE AN **HMO** INSURANCE PLAN, YOU WILL NEED TO REQUEST **AN AUTHORIZATION NUMBER** FROM YOUR PRIMARY CARE PHYSICIAN (PCP) PER INSURANCE REQUIREMENTS PRIOR TO SCHEDULING.

Please follow the steps below…

❖ SCHEDULE INITIAL APPOINTMENT

- **Once your referral has been received and your insurance has been checked, a staff member will contact you to schedule an appointment. If you have an HMO plan, you must contact your PCP to have them obtain *an authorization number* for your appointment to be sent to us prior to scheduling an appointment. **It is your responsibility to request the authorization number from your PCP****

- Once you have scheduled an appointment, **you will receive an email to sign consent forms electronically prior to your appointment.** You will not have to print anything to complete this task.

- Please **complete the attached paperwork and bring with you to the appointment**. Please **arrive 10 minutes before your appointment** to get checked in and complete any other forms. If you are unable to complete the paperwork prior to your appointment or lose the paperwork prior to your appointment, please arrive **30 minutes** before your appointment to complete the paperwork.

- Please **allow 3 hours for your appointment**. **Dr. Buchanan recommends a close family member/friend/caregiver accompany you to the appointment to help provide history and to be involved in the feedback session to review the results of the neurocognitive testing.**

- The appointment with consist of a diagnostic interview, neuropsychological testing (face-to-face interaction with a provider; no scans, computers, or instruments are used), and feedback session to go over results and interpretation. **A synopsis of the test results, diagnoses, and recommendations will be emailed to you and your provider the same day of your appointment. A formal report will be sent to you and your referring provider within 2 weeks following the appointment.**

❖ PREPARE FOR INITIAL APPOINTMENT

- Please bring the following with you to your appointment:
  - **Completed Paperwork with current medication list**
  - **Driver's license and insurance card(s)**
  - **Co-pay (if applicable)**
  - Recent radiology reports
    - Examples: MRI brain, CT head, EEG, sleep study, DAT scan, PET scan, etc.
    - You may request for your provider to email or fax reports to 469-264-5037
  - Glasses and/or hearing aids, if applicable
  - Previous neurocognitive testing or speech therapy records, if applicable
  - **Close family member/friend/caregiver is encouraged to attend the appointment with you**

If you have any questions, please contact our office by:
Email: office@dallasneuropsychology.com
Phone/Text: 214-620-5580
Please understand that the office is *only* comprised of Dr. Buchanan, PhD and Carrie Murdick, MS, CCC-SLP, and we are with patients throughout the day. **We do not have a front office staff**; therefore, **if you call, please expect to leave a message**, and we will do our best to return the call within 24-48 hours. **Texting and emailing questions or requests will receive a faster response**, as we can check these messages in between patients.
We are sorry for any inconvenience this may cause. We strive to provide the best patient care and understand your questions are important.

*****Office Location*****
777 Justin Road
Rockwall, Texas 75087

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:_____ Preferred Pronouns: _____

Dominant hand **(circle one)**: Right Left Ambidextrous Referral Source:_____

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 ☐ Movement Disorder

Kidney and Liver:

☐ Renal Insufficiency ☐ Hepatitis ☐ Cirrhosis/Fatty Liver Disease

Ear / Nose / Eye:

☐ Hearing Loss ☐ Hearing Aids ☐ Seasonal Allergies ☐ Macular degeneration
☐ Glaucoma ☐ Cataract(s) or Date of Surgery _____

COVID-19:

☐ Have you ever tested positive for COVID-19? ☐ Yes ☐ No If yes, when _____?
☐ Have you ever been exposed to someone with COVID-19? ☐ Yes ☐ No If yes, when_____?
☐ Are you vaccinated? ☐ Yes ☐ No Vaccine Brand_____ Boosted? ☐ Yes ☐ No

Other:

☐ Cancer (list types) _____
☐ Chronic Pain (list areas) _____
☐ Arthritis If yes, ☐ Rheumatoid ☐ Osteoarthritis

☐ Childhood developmental delays, injuries, or illnesses: _____

☐ 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: _____

History of abuse, neglect, or trauma? ☐ 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)
Problems swallowing? ☐ Yes ☐ No If so, how long?_____

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:_____Yrs of service?___

Are you experiencing any of the following problems:

Getting lost while driving	☐ Yes	☐ No	Repeating yourself	☐ Yes	☐ No
Forgetting appointments	☐ Yes	☐ No	Can't think as quickly	☐ Yes	☐ No
Forgetting where you are	☐ Yes	☐ No	Understanding conversation	☐ Yes	☐ No
Misplacing items	☐ Yes	☐ No	Changes in handwriting	☐ Yes	☐ No

Difficulty finding the word you want to say	☐ Yes	☐ No
Forgetting name of people you are close to	☐ Yes	☐ No
Forgetting what day or time it is	☐ Yes	☐ No
Reading or retaining what you read	☐ Yes	☐ No
Increased agitation/irritability	☐ Yes	☐ No
Changes in personality	☐ Yes	☐ No

Walking/Balance ☐ Yes ☐ No Have you been falling? ☐ Yes ☐ No

Do you use an assistive device to aid with ambulation ☐ Yes ☐ No What do you use? _____

Have you designated anyone as your POA? ☐ Yes ☐ No If so, who? _____

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

DASS 21

NAME _____ DATE _____

BLACK DOG INSTITUTE

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							

Functional Activities Questionnaire

Administration
Please rate your ability or the patient's ability to complete functional activities using the following scoring system:

- **Dependent on others = 3**
- **Requires assistance = 2**
- **Has difficulty but does by self = 1**
- **Never did and would have difficulty now = 1**
- **Normal (independent, no assistance) = 0**
- **Never did but could do now = 0**

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:	

COMPLETED BY:
_____SELF
_____OTHER:_____

Pfeffer RI et al. Measurement of functional activities in older adults in the community. J Gerontol 1982; 37(3):323-329. Reprinted with permission of The Gerontological Society of America, 1030 15th Street NW, Suite 250, Washington, DC 20005 via Copyright Clearance Center, Inc.

Avivia Health
care management | institute

Geriatric Depression Scale (short form)

Instructions: Circle the answer that best describes how you felt over the past week.

1.	Are you basically satisfied with your life?	yes	no
2.	Have you dropped many of your activities and interests?	yes	no
3.	Do you feel that your life is empty?	yes	no
4.	Do you often get bored?	yes	no
5.	Are you in good spirits most of the time?	yes	no
6.	Are you afraid that something bad is going to happen to you?	yes	no
7.	Do you feel happy most of the time?	yes	no
8.	Do you often feel helpless?	yes	no
9.	Do you prefer to stay at home, rather than going out and doing things?	yes	no
10.	Do you feel that you have more problems with memory than most?	yes	no
11.	Do you think it is wonderful to be alive now?	yes	no
12.	Do you feel worthless the way you are now?	yes	no
13.	Do you feel full of energy?	yes	no
14.	Do you feel that your situation is hopeless?	yes	no
15.	Do you think that most people are better off than you are?	yes	no

Total Score _____