DENT
NEUROLOGIC INSTITUTE

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NEUROPSYCHOLOGIC EVALUATION **J. Aubrey Bottoms, PhD, ABPP-CN**	**DENT NEUROLOGIC INSTITUTE** 3980 Sheridan Dr. Amherst, NY 14226 – 5th floor (716) 250-2000 ext 3101

NAME		DATE OF BIRTH		AGE	
ADDRESS	Street City Zip			WORK: HOME: CELL:	

FILLED OUT BY: (circle) Patient Other (list)___________________________________

Date of Appointment:		Referred by:
Time of Appointment:		Primary Physician: Address:
Accompanied By:	Name: (spouse) (other family) (friend)	
Primary Insurance:		

Please fill out this form, to the best of your ability, and bring it to your scheduled appointment. This must be completed prior to your appointment or you will be rescheduled. If you need to, please have someone help you. You may have answered some of these questions before, but we would appreciate it if you would take a few minutes to answer these important background questions.

What is the reason for this appointment?

When did these problems start? ____

Did they begin (circle one) Slowly Suddenly

Have they changed over time? Better Worse Same

Have you had any neuropsychological testing before? No Yes (where?)___________________________

If so, please arrange to have results sent *before* this examination.

GENERAL HEALTH

1. Do you have/have you ever had any of these health problems? (circle)

Autoimmune Disease   Diabetes   Cirrhosis/liver disease   Cancer   Hydrocephalus
Meningitis   Cataracts   Encephalitis   Toxic Exposure/Chemicals   Stroke   Seizures
Aneurysm   Dizziness   Heart Attack   Electrical Shock   ECT   Dementia   Migraines
High Blood Pressure   Atherosclerosis or "hardening of the arteries"   Hypothermia   sleep apnea
Vitamin deficiency   Hypothyroidism (underactive)   Hyperthyroidism (overactive)   High cholesterol

Seizure disorder (type) ____

2. Do you have any other chronic health problems? (list) ______________________________
____

3. Have you ever (circle):
   Had a head injury   Had a concussion   Been in a coma   Been unconscious   Had a tracheostomy

4. Have you ever become "dazed" or have you lost consciousness ……

While playing sports	YES	NO	Because you were struck by an object	YES	NO
Because of a fight or assault	YES	NO	Because of an auto accident	YES	NO
Because of a fall	YES	NO	For any other reason (e.g., lightning, electrical shock)	YES	NO

If YES to any of the above, please describe:

Year   What happened?   Did you lose consciousness?   Memory loss?   If yes, for how long?
____
____
____

5.	Were there any problems with your mother's pregnancy with you?	YES	NO
6.	Were there problems associated with the delivery of you?	YES	NO
7.	Did you have any significant delays (walking, talking, sitting up) in your development?	YES	NO
8.	Did you have any serious childhood illnesses/diseases/major surgeries?	YES	NO

If yes, please explain: ____

9. Please list any inpatient hospitalizations:
____
____
____

10. Have you ever had:

			When?
Speech therapy	Inpatient	Outpatient	____________________
Occupational therapy	Inpatient	Outpatient	____________________

GENERAL INFORMATION

1. Marital Status

   Never Married   Married or living as married ___________ years
   Separated ______ years   Divorced _______ years   Widowed _______ years

2. With whom do you presently live? (please list) ______________________________

3. Do you have children? NO YES #: __________ Ages (if living at home): __________

4. Is your native language English? YES NO (please list) ______________________

5. Are you right-handed or left-handed? Right Left Ambidextrous
Used to be left-handed but now use right hand for writing

6. How do you spend your free time? ____

____

7. Do you currently have a driver's license? YES NO (Did you ever drive? YES NO)

8. Do you manage your own finances? YES NO

SUBSTANCE USE

1. Do you smoke cigarettes or use tobacco? NO YES _____ packs per day Quit (when) ______________

2. How often do you drink alcohol? NEVER RARELY MONTHLY WEEKLY DAILY

Do you consider yourself an alcoholic? NO YES

4. When you drink alcohol, how many drinks do you usually have on one occasion?

_______________(#) Beverage of choice: ______________________________

5. Do you ever have six or more drinks at one time? YES NO

6. Have you ever been stopped for DWI or DWAI? YES NO Year __________

7. Have you ever been treated for alcohol abuse NO YES Year ________________
drug abuse NO YES Year ________________

PSYCHIATRIC HISTORY

1. Have you ever been hospitalized for a psychiatric problem like anxiety, depression or suicide attempt?
NO YES (please explain): ____
Did you ever have shock treatments? NO YES When? ______________________
2. What psychiatric disorder(s) have you been diagnosed with? ______________________
3. What year were you first ever treated for a psychiatric problem? _______
4. Are you seeing a psychiatrist now? NO YES Name: ______________________
5. Have you ever seen a therapist or counselor? NO YES Reason: ______________________
If yes, are you seeing a therapist or counselor now? NO YES Name: ______________________

EDUCATION & EMPLOYMENT

1. Where did you attend high school? ______________________________
Did you graduate from high school? YES NO
If no, what was the last grade you completed in high school? _______Did you obtain your GED? ______
2. Did you attend college? YES NO ______________________ Where?______________________
If yes, did you obtain a degree? YES NO What was your degree in? ________________
Final GPA ___________________________
Did you attend Graduate School ? YES NO Degree _____________ Major _________

3. What grades did you typically earn in high school? ________________
4. Were you ever in special education classes? NO YES

resource room? NO YES

told you had a learning disability? NO YES

diagnosed with ADD/ADHD? NO YES when? ________ by who?________________

5. Did you have any problems Reading? Spelling? Math?

6. Did you ever have to repeat a grade? NO YES (list) ____________________________

7. Were you ever in the military? NO YES Branch _______________Approx. Dates __________

Did you see combat? NO YES___________________

8. What is your current employment status?

Employed as ____ at ___________________________

Retired from ____ in (year) _____________

Student at ____

Unemployed as of________ Received SSDI since _____ Been denied SSDI ? YES NO

MEDICATIONS

Please List:

<u>CURRENT MEDICATIONS</u> <u>CONDITION PRESCRIBED FOR</u>:

____ ____

____ ____

____ ____

____ ____

<u>OVER-THE-COUNTER MEDICATIONS, VITAMINS, SUPPLEMENTS OR HERBAL PREPARATIONS:</u>

____ ____

____ ____

____ ____

MISCELLANEOUS

Are you involved in any litigation (suing anybody, being sued)? NO YES

Please explain: ____

DISCLOSURE AND RELEASE OF INFORMATION

Any information you disclose during this interview may be disclosed as part of these findings. If you have ever been treated for substance abuse, have abused alcohol or psychoactive drugs, or are HIV positive, this information is critical to the evaluation and will be disclosed as a part of this report. Safety issues concerning yourself or others that are raised during the interview or exam will be addressed. This may include issues related to driver safety or living situation as appropriate. Information leading to suspicion of child abuse or elder abuse must be reported to appropriate authorities. This exam requires your active participation. Inadequate effort may affect the results, and effort assessment and related findings are addressed as part of the results.

Results will be placed in our electronic Dent chart and will be available to other Dent providers. Normally, release of information requires your written consent. However, some insurance companies may require this information for reimbursement purposes. If you are applying for Disability benefits, findings will normally be released as part of the general consent you sign for Social Services unless you advise otherwise prior to their release. Records may also be released in response to a judicial subpoena. If you are seen for an Independent Medical Examinations or were referred by VESID, the report can be released only to the referring agency. Any recording of these proceedings in any form is prohibited.

1) With whom can the doctor *discuss* these findings and your medical care:

____

2) If you were referred by an outside provider, we will send results to the referring physician or provider listed on page 1, and your primary physician:

Primary Physician: ____

Address:____

3) If there is any other *health care provider* to whom you would like us to send the results, please provide his or her name and address below.

Name: ______________________________ Name: ______________________________

Address: ______________________________ Address: ______________________________

______________________________ ______________________________

4) Is this a No-Fault case? __________ NO________ YES, please release records to my Attorney:

Name: ____

Address: ____

- ***To avoid misinterpretation, records <u>will not</u> be mailed to you or family members under any circumstances***.

If you require a copy of the findings for your own records, you must come in to discuss the findings in detail with the referring doctor who is treating you or coordinating your care.

I have read the above and agree to the terms of disclosure.

Signature: ____ Date: ______________________________

Rev. 1/17 Background Form

DENT
NEUROLOGIC GROUP

J. Aubrey Bottoms, PhD
Dent Neurologic Group, LLP
(716) 250-2000 x3101

CANCELLATION POLICY

PATIENT RESPONSIBILITY

By making an appointment, you are agreeing to be seen for a large block of time. If cancellations are made without 48 (business) hours notice, we have no way of using the time we have committed to your care. If that occurs, we must ask you to be responsible for the full cost of the block of time reserved for you (one hour for interview, 2-3 hours for testing). Your medical insurance carrier will not cover this fee.

Cancellations and rescheduling are done ONLY through Dr. Bottoms' secretary, at (716) 250-2000 x3101.

Cancellations are not accepted if made after hours through the service.

RESULTS

Results are provided to the referring physician. You are responsible to follow-up with that provider to obtain results.

Your signature indicates that you understand and accept this policy:

__________________________________ _______________________
Signature Date