

Significant Symptoms

Please indicate whether you have ever experienced any of the symptoms below, when, and briefly describe:

Symptom	Circle Yes or No		When it began	Please briefly describe Problem(s) and Treatments, if any
	No	Yes		
Loss of Consciousness	No	Yes		
Memory Difficulties	No	Yes		
Weight Changes	No	Yes		
Chronic Pain	No	Yes		
Feeling Shaky	No	Yes		
Blurred/Double Vision	No	Yes		
Changes in ability to Smell	No	Yes		
Chronic Ringing in Ears	No	Yes		
Muscle Jerks or Twitches	No	Yes		
Bowel or Bladder Problems	No	Yes		
Speech Difficulties	No	Yes		
Sleep Difficulties	No	Yes		
Decreased Energy	No	Yes		
Decreased Motivation	No	Yes		
Decreased Happiness	No	Yes		
Social Isolation	No	Yes		
Frequent Headaches	No	Yes		
Dizziness	No	Yes		
Allergies	No	Yes		
Asthma	No	Yes		
Seizures	No	Yes		
High Fever	No	Yes		
Frequent Anxiety	No	Yes		
Persistently Depressed Mood	No	Yes		
Nightmares	No	Yes		
Angry Outbursts	No	Yes		
Mental Confusion	No	Yes		
Feelings of Paranoia	No	Yes		
Excessive Worry	No	Yes		
Unusual/Frightening Thoughts	No	Yes		

Diagnostic Examinations

Please describe results of any neurological tests/examinations of your brain:

	MRI	CT	Brain Scan or SPECT	EEG	Neurological Examination /Other
Approximate Date					
Describe results					

Other (describe): _____

Medical History Please describe briefly your history of past and present serious illnesses and treatment.

Past and present illnesses, diseases, syndromes	Dates (From - To)	Treatment (Surgery/Medication)	Current Status

Do you suffer from:	High Blood Pressure	Diabetes	High Cholesterol	Other: _____
Treatment controlling it? (Yes No)				

Describe past Accidents/Falls leading to injury	Dates (From - To)	Surgery/Medications/Treatment

Describe any Other Hospitalizations/Surgeries	Dates (From - To)	Treatment (Surgery/Medication)	Current status

Activities of Daily Living

Do you currently hold a driver's license? **Yes** **No** (If No, how do you get around?) _____
 If yes, are you currently driving? **Yes** **No** (if No, who drives you?) _____

Have your **driving** abilities worsened or become bad? (describe problems) _____ **No** **Yes**
 Do you have trouble showering/dressing, cooking, cleaning, or remembering to take medicines or eat? **No** **Yes**
 Have you left items on the stovetop or in the oven and forgotten them? **No** **Yes**
 Does someone, other than yourself, manage your finances? (If yes, then who): _____ **No** **Yes**
 Have thinking problems made you unable to pay bills, balance checkbook, invest, shop, make change? **No** **Yes**
 What chores do you perform around the house? _____
 What sorts of things do you do for fun? _____
 Describe what you do and how often you spend time with family or friends relaxing or enjoying an entertaining or recreational activity?: _____
 Describe how you get along with other people? _____

Current Medications

List names of Current Medications	Date medication prescribed	Dose (mg) (total per day)	Name of doctor who prescribed	What illness is medication for?	How well is this medication working

Alcohol Use

What type of alcohol (beer, vodka, wine) do you usually drink? _____ Are you currently drinking alcohol? **No** **Yes**
 Total Number of Years drinking on a fairly regular basis _____ Have you ever had a drinking problem? **No** **Yes**
 Average Amount you regularly drink (for example: 1 drink/week, 5 drinks/day, etc.) _____
 Have you been involved in any treatment for: (circle) **Drinking Alcohol** (including A.A.)/ **Using Drugs**: **No** **Yes**

Please list any current, recent or past drug use and any treatment for drug use:

Type of Alcohol or Drug	Average Amount Used per week	Describe any treatment?

Smoking

If you smoked previously, when did you stop? _____ Are you currently smoking? **No** **Yes**

Briefly describe attempts to quit smoking: _____

Approximately how many years smoked in lifetime: _____ Average number of packs/day _____

Psychological/Psychiatric

Have you ever had any treatment for psychiatric/psychological difficulties (relationship counseling, psychological counseling, medicines for depression or anxiety, etc.): If yes, please describe below: **No** **Yes**

Problem	Date (From - To)	Describe Treatment received

Family Medical History

Please describe any family history of medical/neurological illness (Stroke, Alzheimer's, Dementia, High Blood Pressure) (include medical problems in all of your blood relatives, including psychiatric or psychological problems)

Education

Last grade completed? _____ At what age? _____ Usual grades (A,B,C,D,F) in school? _____

Did you get a GED? **No** **Yes** Or did you get a high school diploma? **No** **Yes**

Did you ever repeat a grade? If yes, which grade(s)? _____ **No** **Yes**

Have you ever been enrolled in special education or learning disability classes? **No** **Yes**

If Yes, please describe: _____

List degrees beyond high school (medical, associate, bachelors, masters, doctorate, etc.)? _____ in _____

From what colleges _____

Please list any technical training or college education you have received since high school:

Have you taken intelligence, cognitive, achievement, or neuropsychological tests in the past? **No** **Yes**

If Yes, please describe: _____

Vocational History Are you currently working? **Yes** **No** (please list past jobs, even if not presently working)

Please outline your recent vocational history beginning with your most recent (or current) employment:

Dates (began -- ended)	Company Name	Job Title	Describe your duties	Why did you leave?
Start here with most recent job				
1. --				
2. --				
3. --				
4. --				

Are you currently receiving any type of disability income? If Yes, please explain: _____ No Yes
 Are you currently in the process of applying for disability income?(SSI or others) explain? _____ No Yes
 Have you ever been arrested for anything (if yes, describe) _____ No Yes

Have you ever served in the military? If yes, please complete the following: No Yes

Dates	Branch	Highest rank	Type of discharge	Combat duty (Y/N)

Marital Status (circle)? Widowed Single Separated Divorced Married

Spouse's name	Age when you married?	How long did you remain married?	Describe how you get along with that person now: (Good, Bad, No Contact, etc.)
1st:			
2nd:			
3rd:			
4th:			
Current spouse:			

Who currently lives with you? _____

Family

For the following family members please list their age, education, occupation, and how well you get along:

Relation	Name	Age	lives with you? Yes/No	Highest Grade Completed	Occupation	How well do you get along (good, bad, etc.)	List Health Problems
Spouse							
Children							
Mother							
Father							
Brothers and Sisters							
Other family members							

STOP, Please do not write below this line!

Who was present for this interview: Patient Who else: _____

Authorization to Obtain and Release Records:

Birmingham Neuropsychology LLC, 2018 Brookwood Medical Center Dr., Prof Ofc Bldg #310
Richard L Azrin, Ph.D. and Cheryl Millsaps, Ph.D. Voice: (205) 877-2956, Fax: (205) 877-2878

Patient Name: _____ Date of Birth: _____

Social Sec. # _____ Date(s) of requested records: _____

I hereby authorize the above providers to obtain and release the protected information specified below.

Please list any restrictions on this release of information _____

Name _____ Phone _____ Fax _____

Address _____
City State Zip

Name _____ Phone _____ Fax _____

Address _____
City State Zip

Name _____ Phone _____ Fax _____

Address _____
City State Zip

Name _____ Phone _____ Fax _____

Address _____
City State Zip

Name _____ Phone _____ Fax _____

Address _____
City State Zip

Records to be Obtained: Please send copies of all EEG, MRI, CT, History and Physical, and progress notes.

Release: This form when completed and signed by you, authorizes me to release, as well as to obtain, protected information from your clinical record to/from the person(s) you designate. I hereby authorize Dr. Richard L Azrin and Dr. Cheryl Millsaps and his/her administrative and clinical staff to release any and all contents of my chart (including at least billing information, psychotherapy/progress notes, test results/data, reports, visit information, prescriptions, medical information, documents provided by patient, insurance/third party forms/reports, records received by others). This information may be released to and/or obtained from the above individuals and my referral source. Providers and staff residing in 2018 Brookwood Med Center Dr. POB 310-311 may also obtain and release my information between each other. I am requesting my provider release this information to aid in treatment, assessment, and/or provide information about me to others. This authorization shall remain in effect for 7 years from the date signed. However, you have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my provider generally may not condition mental health services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. I hereby release the above treatment/assessment providers and their respective medical staff and office from any and all liability and claims arising out of or relating to the disclosure and/or release of confidential and/or privileged information.

Name of patient and/or responsible party Signature of patient or responsible party Date

If signed by patient's representative, please print representative's name and describe representative's authority to act for the patient

***** Please FAX records to Fax# (205) 877-2878 *****