Child Neuropsychological Evaluation

Richard Azrin, Ph.D., Birmingham Neuropsychology, LLC
2018 Brookwood Medical Center Drive, Professional Office Building Suite 310, Birmingham, AL 35209
Phone (205) 329-7815 Fax (205) 329-7816

Doctor / Other:_____ has referred the patient:_____for testing/evaluation.

Parent/Guardian:_____ and the Patient: _____ are scheduled to:

1) Discuss the history on Appointment Date:_____Time:_____ (for about 1 hour) (child may take meds)
The patient and parent/guardian will first come into the office for an interview for about ONE HOUR OR LESS. The doctor will spend time with the patient and any relatives/friends/significant people to get background information. Please bring the bottles for all of your child's current medications or a list of the exact medication names, daily dosages, and who prescribed them.

2) Evaluation/Testing will be Appointment Date:_____Time:_____ (usually for 4 hours)
For younger children, there will usually be a 2nd Appointment Date:_____Time:_____ (for 2-4 hours)
Medications: On the day of testing, if already prescribed, **don't give stimulant medications to the child** (Ritalin, Adderall, Concerta, Metadate, etc.) unless otherwise directed by Dr. Azrin, but bring stimulant medications with you. We perform part of the evaluation prior to giving stimulants, and then we will give the medications prior to continuing testing. Give child breakfast / a good nights sleep before the evaluation, bring snacks/drinks for patient, if possible.
Forms: Please have all teachers fill out the **Teacher Report Form** and the **Brief** (make copies as needed). Each parent/guardian should complete their own **Child Behavior Checklist** and the **Brief** separately. Please bring all forms to this appointment, completed. A lunch break will usually be taken at noon, unless testing can finish by 1 pm. **Overall, the testing usually lasts from 4 to 8 hours spread out over 2 testing days, (older teens may do it in 1 day)**. Most children find the assessment interesting and fun.

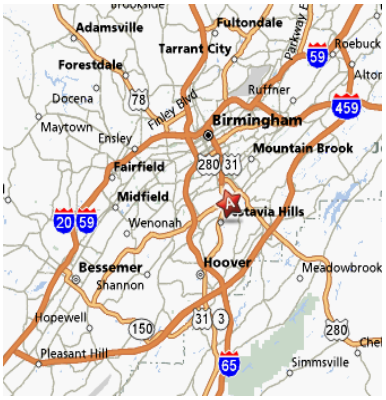
3) Results will be given on: Appointment Date:_____Time:_____
The test results will usually be explained in a follow-up appointment with Dr. Azrin 2-7 days after the evaluation is completed. (If patient has follow-up with a referral doctor, please schedule that follow-up at least 2 days after test results are given).

These assessments are commonly requested for individuals who have attention deficit disorder, learning disabilities, or who have experienced an accident, illness, seizure, psychological difficulties, stroke, or anything that may change the way their brain works. The evaluation is designed to assess what changes have occurred or problems children have, and look at what this means to your child's life. Here are a few common situations that bring people to a neuropsychologist:

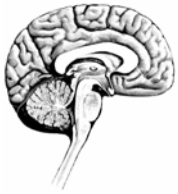
- A child is having difficulty with behavior or schoolwork and teachers have raised the question of a learning disability, attention deficit disorder, processing disorder, or some other developmental disorder.
- A child begins to notices a problem with forgetfulness after suffering a head injury or an accident.
- A child is depressed or anxious and their ability to think has become worse.
- A child has suffered some injury to their brain, and they may now have difficulty functioning in some areas of their lives.

Richard L. Azrin, Ph.D., is a Licensed Psychologist and Clinical Neuropsychologist. A neuropsychologist has specialized training in understanding how our brain works and how it affects our behavior, thinking, and personality.

The results of the tests will be explained in a separate follow-up appointment after the evaluation is completed. Every effort will be made to help you understand your child's strengths and problem areas, and what they might mean to your child's life (e.g., school opportunities and day-to-day situations). This will help you look at ways to get around some of the problem areas and help plan for the future. We look forward to meeting with you and your child. Thank you for your time and effort.



Directions: 1) If you are coming **from Vestavia** towards Homewood on Hwy 31 North (Montgomery Hwy), take the Brookwood Medical Center Dr exit before Lakeshore Dr (Shades Creek Pkwy/ Hwy 149). At the end of the ramp turn right. 2) If you are coming **from 20/59**, take exit 126A to merge onto Hwy 31 South. Drive about 6.2 miles to the Brookwood Hospital exit (Brookwood Medical Center Dr), go to the end of the ramp and turn Left. 3) If you are coming from Lakeshore Dr (Hwy 149) at **I-65 or from 280**, go down Lakeshore Dr/149 and turn onto Hwy 31 South. Take the Brookwood Hospital exit and go to the end of the ramp and turn Left. 4) Go past the first stop light and turn right into the Blue area of the parking deck. Our office is in the Professional Office Building (abbreviated POB) of Brookwood Hospital. From the Blue parking deck the crosswalk will take you to the POB 2nd floor, take the elevator to the 3rd floor. Then go to your left to Suite 310.



Birmingham Neuropsychology
Voice: (205) 329-7815, (205) fax: 329-7816

Richard L. Azrin, Ph.D.

CHILD PATIENT INFORMATION FORM

CONFIDENTIAL

Instructions: Please complete this form as accurately and completely as you can. A doctor will discuss your responses with you.

Child's Name: _____ **Child's birth date: _____/_____/_____ Eval Date____/____/____**

Address_____ Who completed this form _____

Child's Soc Sec Num:_____ Name of Insured:_____ _____ Insurance Company_____

Child's Age_____ Current Grade _____ Last Grade completed _____Sex____ Race_____ Height____ Weight____

Parent/guardian Name_____ Home Phone: _____ Work/other Phone_____

Parent/guardian Name_____ Home Phone: _____ Work/other Phone_____

Who referred you to this clinic? (**Full Name and Phone**):_____

When is your next appointment to see the referring doctor? _____/_____/_____

What difficulties, symptoms, or complaints does your child have that led to your referral here?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medical History

Please indicate whether your child has experienced any of the symptoms below, when, and briefly describe

	Circle Yes / No		When Began	Please Describe problems
Loss of Consciousness	No	Yes		
Memory Difficulties	No	Yes		
Weight Changes	No	Yes		
Chronic Pain	No	Yes		
Shakiness	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		
Fever	No	Yes		
Frequent Anxiety	No	Yes		
Persistently Depressed Mood	No	Yes		
Nightmares	No	Yes		
Angry Outbursts	No	Yes		
Mental Confusion	No	Yes		
Hyperactive Behavior	No	Yes		
Excessive Worry	No	Yes		
Aggressive Behavior	No	Yes		
Impulsive Behavior	No	Yes		
Poor Motor coordination	No	Yes		
Tantrums	No	Yes		
Destructive Behavior	No	Yes		
Odd Behaviors	No	Yes		
Learning Problems	No	Yes		
Compulsive Behavior	No	Yes		
Shy/withdrawn	No	Yes		
Moody	No	Yes		
Fearful/Anxious	No	Yes		

Other:_____

_____

_____

Describe results of pertinent medical tests (for example, MRI, CT scan, EEG, brain scan, etc...): _____

_____

Please describe briefly your child's history of serious illnesses, accidents, injuries, and treatment.

Past and present illnesses, Diseases, syndromes	Dates (From - To)	Treatment: (Surgeries/Medication)	Current Status

Describe past accidents leading to injury	Dates (From-To)	Surgery/Medications/Treatment	Current Status

Describe Other Hospitalizations / Surgeries	Dates (From-To)	Surgery/Medication/Treatments	Current Status

Current Medications

List names of Child's 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

Developmental History

Child's Place of Birth: (City and Hospital)_____

Child was (circle one): Full-term Premature How many weeks premature? _____

Birth Weight: _____ Birth Length: _____

Medical complications at birth or soon after delivery? (e.g., long/hard labor, blue baby, cord around neck, etc...):

_____

Please circle any of the complications experienced by the child's mother during pregnancy.

Infections	high fever	chemical exposure	vaginal bleeding
accidents/falls	anemia	nausea/vomiting	lack of fetal movement
sugar in urine	large weight gain	weight loss	high blood pressure
extreme fatigue	kidney disease	measles	Rh/blood problems
toxemia	urinary problems	early contractions	Other problems
x-rays	drugs		

Please briefly describe the nature of any of the items circled: _____

_____

_____

How many cigarettes did the mother smoke per day during pregnancy? _____

How many alcoholic drinks per week, on average, did the mother have during pregnancy?_____

Medications/drugs taken by mother during pregnancy? _____

_____

Was anesthesia used during delivery? Yes No Were forceps used during delivery? Yes No

Was labor induced? Yes No Did the baby have meconium staining Yes No

Was the baby placed in an incubator/intensive care Yes No For how long? _____

How long was the baby in the hospital after delivery? _____

Developmental Milestones If all milestones listed below occurred at normal ages, please check here _____

Otherwise, at what age did the Child first (if you are not sure if age was normal, **please estimate** - in months or years -):

Smile	_____	Dress self completely	_____
Hold head up alone	_____	Ride a tricycle	_____
Sit alone	_____	Use single words	_____
Stand alone	_____	Use sentences	_____
Walk alone	_____	Toilet trained - bowel	_____
Feed self	_____	Toilet trained - bladder	_____

Has Child had any of the following (list dates if known):

Asthma	Broken bones	Chicken Pox	Convulsions
Ear infections	Eating problems	Encephalitis	Fainting spells
Head Injuries	Hearing problems	Lead Poisoning	Measles
Meningitis	Mumps	Other poisoning	Pneumonia
Rheumatic fever	Scarlet fever	Severe headaches	Staring spells
Tonsillitis	Vision problems	Seizures	

Psychological/Psychiatric history

Has child ever had any treatment for psychiatric/psychological difficulties (psychological counseling, medicines for depression, ADD, hallucinations, behavior problems): If yes, please describe below: N**o** **Yes**

Problem	Date (From - To)	Describe Treatment received

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

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

Please indicate if the child's parents, brothers, sisters, or any relatives have had any of the following, and DESCRIBE:

	Circle Yes/No		Please Describe
Known genetic (inherited) conditions or chromosomal abnormalities (e.g., Down syndrome)	No	Yes	
Birth defects (e.g., spina bifida, heart defects)	No	Yes	
Hydrocephalus ("water on the brain")	No	Yes	
Mental Retardation	No	Yes	
Learning Problems	No	Yes	
Slow Development	No	Yes	
Language/Speech Problems	No	Yes	
Disturbed Growth Pattern	No	Yes	
Muscle or Motor Problem	No	Yes	
Blood Disorders (e.g., hemophilia, sickle cell disease, etc...)	No	Yes	
Neurological Disorders	No	Yes	
Epilepsy, Seizures, Convulsions	No	Yes	
Other serious medical problems	No	Yes	

Family Medical History

Please describe any family history of medical/neurological illness (Stroke, Alzheimer's, Dementia, High Blood Pressure)

_____

Family History of Psychological / Psychiatric / Drugs

Please list any of your child's family who have received treatment for psychiatric, psychological, drug or alcohol problems:

Which family member (mother, brother, etc.)	Describe Psychiatric or Drug/Alcohol Problem	Describe treatment

Child's School/Education History

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

Best Subjects?_____ Worst Subjects?_____

Have any grades been repeated? If yes, which grade(s)?_____ **No** **Yes**

Has your child ever been enrolled in special education or learning disability classes? **No** **Yes**

If yes, please describe:_____

Has your child previously taken intelligence, cognitive, achievement, or neuropsychological tests? **No** **Yes**

If Yes, please list names of people who tested your child and describe tests/results (please bring copy to evaluation, if possible):

_____

Family

Current Living Situation? (Who lives with the child?) _____

For the following family members please list their **age**, **education**, **occupation, and how well child gets along with each:**

Relation	Name	Age	lives with child? **Yes/No**	Highest Grade Completed	Occupation	How well do you get along (excellent, good, bad, etc.)
Mother						
Father						
Step-parents						
Legal guardian						
Grandparents						
Brothers And Sisters						
Other family members						

Activities

What chores does your child perform around the house?_____ _____

_____

List your child's favorite activities: _____

_____

Would you describe your child as an affectionate child? Please describe: _____

_____

Please describe your typical approach to discipline and child behavior management:

_____

_____

How well does your child get along with similar aged peers?

_____

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

Observations/Notes _____

_____

_____

New Patient Information

Patient Name (Last)_____(First)_____(M.I.)_____

Address_____City_____State_____Zip_____

Sex: **M F** Birth Date _____ Age_____ Social Security Number _____

Home Phone (___) _____Work (___) _____Cell (___)_____

Marital Status: _____ Drivers License #: _____

Email (Test results may be sent to this address): _____

Spouse/Partner Name: _____ Spouse/Partner Soc Sec #: _____

Spouse place of Employment: _____ Spouse Phone #: _____

Emergency Contact _____ Relationship to Patient _____

Emergency Contact Phone (___)_____

Insurance Information

1) Name of **Primary** Insurance: _____

Contract #_____ Group #_____Effective Date_____

Policy Holder's Name: _____ DOB_____ Soc Sec Number _____

Relationship_____ Employer_____ Phone #'s: _____

2) Name of **Secondary** Insurance: _____

Contract #_____ Group #_____Effective Date_____

Policy Holder's Name: _____ DOB_____ Soc Sec Number _____

Relationship_____ Employer_____ Phone #'s: _____

Request for Confidential Handling of Health Information

Complete only if you want communications regarding your health care information sent to an alternate address or telephone other than listed above. I request that my provider handle my confidential health information as described below. All reasonable requests to receive communication of your health information by alternative means and/or locations will be granted. Please describe the alternative means below (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

Alternate Address_____

Alternate Telephone_____ Alternate Telephone_____

Agreement

If your insurance company OR health plan requires pre-approval OR referral for your visit, it is your responsibility to obtain this referral or YOU will be personally responsible for the bill. I, the undersigned (patient or legal guardian), authorize medical treatment to be rendered by the provider and assume financial responsibility. In the event the account is not paid in full within 90 days*, the undersigned agrees to pay all costs of collection including reasonable attorney fees, and hereby waives all rights of exemption under the constitution and laws of the State of Alabama. I also authorize the release of my medical records to my physicians and insurance carriers. If the provider has a contractual arrangement with your insurance carrier, the balance refers only to the amount that you are required to pay. I understand that all of the providers in the offices at 2018 Brookwood Medical Center Drive, POB Suite 311 and POB Suite 310 are independent practitioners (not partners) although they are sharing office and staff. Your signature below also indicates you have received the Alabama Notice Form: Notice of Policies and Practices to Protect the Privacy of your Health Information and agree to its terms and serves as an acknowledgement that you have been shown or given a copy of the HIPAA Notice Form.

COMMUNICATION REGARDING MY ACCOUNTS: Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any services and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) Voicemail messages, and other forms of communication.

Informed Consent: I agree to participate in evaluation/treatment, and the purpose has been explained to me and/or my guardian/representative.

Signature of Patient or Responsible Party: _____ Date_____

If signed by a responsible party, describe that representative's authority to act for the patient_____

Richard L. Azrin, Ph. D. ● Cheryl Millsaps Azrin, Ph. D.
2018 Brookwood Medical Center Drive
Professional Office Building, Suite # 310 Birmingham AL, 35209
Voice: (205) 329-7815 ● Fax (205) 329-7816

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 the doctor's last progress notes.

Release: This form when completed and signed by you, authorizes me to release, as well as obtain, protected information from your clinical record to and from the person(s) you designate. I hereby authorize Dr. Richard Azrin, Dr. Cheryl Millsaps, Leslie Kahn, LCSW, Dr. Stuart Tieszen, Dr. Frank Brotherton, Dr. Kristi Yarbrough, and/or his or 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 should only be released to and/or obtained from the above individuals.
I am requesting my psychologist, psychiatrist, or social worker release this information to aid in treatment and/or assessment and/or provide information about me to others. This authorization shall remain in effect indefinitely. 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 psychologist, psychiatrist, or social worker generally may not condition psychological 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.
Informed Consent: I agree to participate in evaluation/treatment, and the purpose has been explained to me and/or my guardian/representative.

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

If signed by patient's representative, a description of representative's authority to act for the patient is provided above.

***** Please fax records to Fax# (205) 329-7816 OR call Voice # (205) 329-7815**

Parent/ Guardian please complete

Birmingham Neuropsychology, LLC
Phone (205) 329-7815 • Fax (205) 329-7816

Patient Name: _____ Who completed this form: _____ Date:_____

Is the patient experiencing any of the following problems beyond what others seem to experience?

*** Only answer YES if problem present for at least 6 months and if the problem is much more frequent than you would expect for that age person**

Yes	No	Fails to pay close attention to details or makes careless mistakes
Yes	No	Often has difficulty **sustaining** attention when doing things or playing
Yes	No	Often does not listen when spoken to directly
Yes	No	Often does not follow through on instructions, or fails to finish schoolwork, chores, or work duties
Yes	No	Often has difficulty organizing self when doing things
Yes	No	Frequently avoids, dislikes, or doesn't want to do things that take sustained mental effort (homework or schoolwork)
Yes	No	Often loses things needed for playing or school (pencils, books, tools, assignments)
Yes	No	Is often easily distracted by things going on elsewhere (noises, other people, etc.)
Yes	No	Is often forgetful on daily basis

Yes	No	Often fidgets with hands or feet, or squirms in seat alot
Yes	No	Often leaves seat in class or whenever supposed to be sitting down
Yes	No	Often runs about or climbs (if over 11 y/o – is child overly restless)
Yes	No	Often can't play or do things quietly
Yes	No	Often acts on the go like child is driven by a motor
Yes	No	Often talks excessively

Yes	No	Often blurts out answers before questions completed
Yes	No	Often has difficulty waiting for his/her turn
Yes	No	Often interrupts or intrudes (butting into conversations or games)

Yes	No	Have all the above problems been present since before age 12
		(or when did the above symptoms start _____