Adult Neuropsychological Evaluation

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

** *YOU WILL HAVE 3 APPOINTMENTS*, *AND* ***YOU WILL NOT BE TESTED ON THE FIRST APPOINTMENT*** **

1) First Appointment	**Date / Time**	**What to Bring**	**Who to Bring**	**Medications**
Interview with Dr. Azrin for about 1-2 hours (**No Testing**)		Fill out and bring the **Adult Patient Information Form**	If the patient has memory issues, please bring significant people, such as friends, spouse, or relatives.	**Take your usual medications**

2) Second Appointment	**Date**	**Time**	**Hours**	**What to Bring**	**Medications**
Evaluation or Testing with a testing assistant	_____	____	Testing lasts _____Hours	Drinks/Snacks Reading Glasses Hearing Aids	Medications to skip: ◯_____ _____ Or: ◯ take your usual medications

3) Third Appointment	**Date**	**Time**	**How Long (usually)**
Go over Results With Dr. Azrin	_____	_____	1 hour

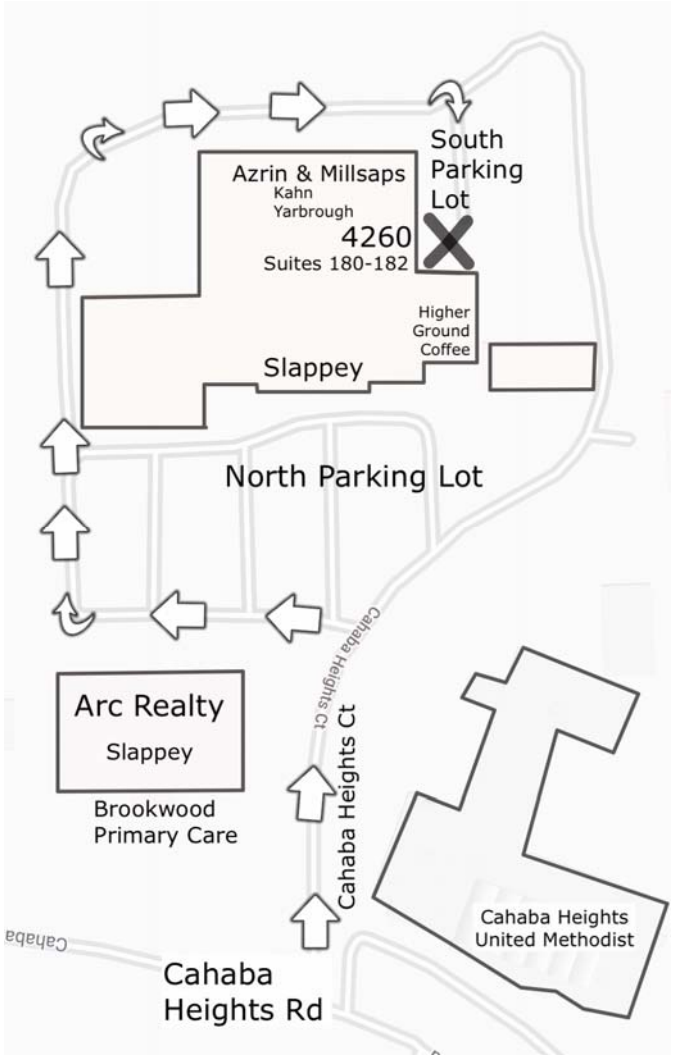
Directions:

From Downtown or Hwy 31-Take Hwy 280 going South. You will pass Whole Foods on your left. Be in the Right lane. Take ramp to Cahaba Heights on the Right. At the end of the ramp turn Left onto Pump House Rd. Pump House Rd turns into Cahaba Heights Road. You will pass Starbucks on your Left. Immediately after Cahaba Heights Methodist Church, Turn Right onto Cahaba Heights Court, just before the Slappey Communications Sign.

From Hwy 459 or Hwy 280-Turn into the Summit shopping Center on Summit Blvd. Pass the shopping areas on both sides. Turn Left on Cahaba Heights Road; you will see two veterinarians at that intersection. You will then pass Cahaba Cycles on your Left. Turn Left on Cahaba Heights Court just past the Slappey sign. If you see Starbucks on your right you have gone too far.

Parking is in the back of the 4260 Building:

After you turn onto Cahaba Heights Court, go straight ahead until you see the Slappey Communications Building at 4260.
We are on the opposite side of the entire building in the **South Parking lot**, which is just behind Higher Ground Coffee. Circle around the left side of the entire building by following the Doctors Offices signs to the South Parking Lot in the back of the entire building, or park in front of Higher Ground Coffee and Walk to the right of Higher Ground Coffee to the back lot (follow the arrows to the South Parking lot in the parking lot map you see here)



Answers to Frequently Asked Questions:

1) **What is the reason for an evaluation:** Assessments are requested for anything that may have affected the brain, depression, anxiety, medical issues, aging concerns, difficulty with daily activities, or thinking/memory/attention/learning issues.
2) **Who does the Evaluation**: Dr. Azrin and his testing assistants. Dr. Azrin is a Licensed Neuropsychologist. He has specialized training in how the brain works and how it affects behavior, thinking and personality.
3) **What will be Evaluated**: Concentration, memory, language, problem solving. Patients will be asked questions verbally, and on computer, and with paper and pencil tests.
4) **What to Expect**: The neuropsychological assessment does not involve a medical check-up. Dr. Azrin will go over your history at the first appointment for about an hour. Testing will be done at the second appointment, and usually lasts 2-6 hours.
5) **When will the report be ready**: Dr. Azrin will send your report by 1 week after going over results with you. Please schedule follow-up with your referral doctor after this time.

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

Richard L. Azrin, Ph.D.

ADULT PATIENT INFORMATION FORM

CONFIDENTIAL

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

Patient's Name Mr/Ms/Mrs _____ Evaluation Date:____/___/____ Date of Birth:___/____/____

Soc Sec Num:_____ Date form was completed:___/___/____ Who completed this form?_____

Address _____ Home Phone_____ Work/other Phone_____

Insurance Company_____ Policy #_____ Insured's Name:_____

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

When is your **next appointment** to see that referring doctor/ counselor? _____

Besides referral source, who else should get a copy of your report:_____

Patient's Age_____ Gender (circle): Male Female Race:_____ Are you right/left Handed? _____

Presenting or Current Problems

What difficulties, symptoms, or complaints do you have that led to your referral here?_____

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
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

Habits: What time do you get in bed?_____ How long does it usually take to fall asleep:_____
What time do you wake up: _____ Nap times: _____ Average daily total hours sleep: _____
Caffeine: Cups of coffee: ____ Cans of Soda: ____ 8 oz glasses of tea: ___ How late do you finish drinking it: _____
Exercise type: _____ How often: _____ How many minutes each time:_____

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	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 the exact names/daily dosages & prescriber or bring bottles for all 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:_____

New Patient Information

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

Address_____City_____State_____Zip_____

Sex: **M F** Patient's Employer_____

Birth Date _____ Age_____ Social Security Number _____

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

Marital Status: _____ Driver License #: _____

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

Spouse/Partner Name _____ Spouse Soc Sec #:_____

Spouse place of Employment _____ Spouse Phone #: _____

Other 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 4260 Cahaba Heights Court, Suites 180-182, Vestavia, AL 35243 are independent practitioners (not partners) although they are sharing office and staff. Your signature below also indicates you have seen or 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.
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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. Frank Brotherton, Dr. Kristi Yarbrough, Dr. Christopher Litton 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**