

## Adult Neuropsychological Evaluation

Richard L. Azrin, Ph.D. □ Cheryl Millsaps, Ph.D.

Birmingham Neuropsychology

2018 Brookwood Medical Center Drive

Professional Office Building – Suite 310 - Birmingham, AL 35209

Phone 205.329.7815 Fax 205.329.7816 www.brookwoodclinic.com

Doctor / Other: \_\_\_\_\_ has referred the patient: \_\_\_\_\_ for testing/evaluation.

1) Interview to discuss history on Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ (for about 1 hour)

The patient will first come in to the office for an interview for about ONE HOUR OR LESS. The doctor will spend time with the patient and any significant people / friends / relatives to get background information.

Please fill out the Adult Patient Information Form before the appointment. Bring the following to the appointment: the enclosed form, list the exact names and daily dosages and who prescribed medications (or bring bottles for all current medications).

2) Evaluation Evaluation/Testing on Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ (for 4-8 hours)

The testing usually lasts from 4 to 8 hours, depending on the patient's energy level / abilities. Rest breaks are given. Some find the evaluation a bit tiring, so please be sure the patient has had a good meal and a good nights sleep before the evaluation, if possible. Please bring snacks/drinks if needed, glasses /hearing aids if needed for hearing/reading.

3) Results will be given on: Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

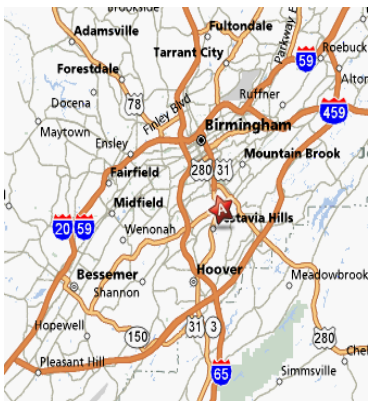
The test results will usually be explained in a follow-up appointment with Dr. Azrin 2-7 days after the evaluation is completed. (If patient has followup with a referral doctor, please schedule that followup at least 1 day after test results are given)

These assessments are commonly requested for individuals who have experienced an accident, stroke, or anything that may change the way the brain works. The evaluation is designed to assess what changes have occurred and look at what this means to the patient's life. Here are a few commons situations Dr. Azrin and Millsaps assess:

- A person begins to notice a problem with forgetfulness after suffering a head injury in an accident.
- A person is depressed or anxious and their ability to think has become worse.
- An elderly person is experiencing memory lapses and wants to find out if this is just a normal part of aging or the sign of a memory problem.
- A person has suffered some injury to their brain, and they may now have difficulty functioning in some areas of their daily lives.

You assessment will be conducted by Dr. Richard L. Azrin or Dr. Cheryl Millsaps, Licensed Neuropsychologists. They have specialized training in how the brain work and how it affects behavior, thinking and personality.

The doctors will be assessing specific skills using a wide range of activities. These skills include concentration, memory, language, and problem solving. Some of the ways these are tested include answering questions, remembering certain information and writing things down. The neuropsychological assessment does not involve a medical check-up, or a psychiatric assessment. Assessments are usually of great value to family, friends, doctors or therapists in helping them to understand your problems better and providing you with the best support.



**Directions:** 1) Coming from Vestavia towards Homewood on Hwy 31 North (Montgomery Hwy), take the Medical Center Drive exit before Lakeshore Dr. At the end of the ramp turn **Right** or Coming from Lakeshore Parkway at I-65, go down Lakeshore and turn right onto Hwy 31 South. Take the Brookwood Hospital exit and go to the end of the ramp and turn Left. 2) Go past the first stop light and take a right into the parking deck. Parking for our office is in the Professional Office Building (abbreviated POB) of Brookwood Hospital, the **Blue are of the parking deck**. When you park in the blue area, the crosswalk will take you into the POB 2<sup>nd</sup> floor, take elevator to the 3<sup>rd</sup> floor. Then go to your left to Suite 310.



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If you have undergone any of the following brain scans, doctor's notes, or labs please bring results of those scans or labs with you for your next appointment.

- Brain MRI in the past two years. Report only, no films or CDs needed.
- Brain MRA in the past two years. Report only, no films or CDs needed.
- Head CT. Report only, no films or CDs needed.
- EEG (brain wave scan.) Report only.
- Labs in the past six months. (Blood work)
- Carotid ultrasound. Report of results.
- If you have been hospitalized in the past year please have the hospital send a history and physical and a discharge summary.
- Chart notes, including at least the last chart note ordering this evaluation.



**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

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

Describe past <b>Accidents/Falls</b> 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 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 <b>Alcohol</b> or <b>Drug</b>	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? <b>Yes/No</b>	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 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 given a copy of the HIPAA Notice Form. Informed Consent: I agree to participate in evaluation/treatment, and the purpose has been explained to me and/or my guardian/representative. 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.**

**Signature of Patient or Responsible Party:** \_\_\_\_\_ **Date** \_\_\_\_\_

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

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**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 doctors 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, Margaret Smith, LCSW, Dr. Stuart Tieszen, Dr. Elena Herndon, Dr. Joel Melvin, Jeannie Briscoe, LCSW, Dr. Eric Crowe, 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**