Stephanie Moore, PsyD, FACPN
American Board of Neuropsychology
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To Patients of Dr. Moore:

Please read the following very carefully and sign and witness <u>before coming to the appointment</u>. Your signature at the bottom of the page will indicate that you have read, understand, and agree to adhere to these policies.

1. All Professional Fees are due and payable at the time of service. These charges are the total responsibility of the patient. Please plan to make payment for your charges at the end of each appointment.

2. **<u>Cancellation of an appointment must be done 24 hours before the appointment time, during office hours, between 10:00 a.m. and 5:00 p.m. This allows for the scheduling of another patient in that time slot. Any appointment not handled in this manner will be charged at the full amount of the normal office fee</u>.**

3. Insurance is billed as a courtesy by this office and cannot be counted upon as payment for services. This, again, is the responsibility of the patient.

4. If you have need of special services, such as a written progress report of your care, etc., this must be done in writing and given a reasonable amount of time for the completion thereof, prior to the date needed. Any special requests will be the exception and not the rule.

I, the undersigned patient, do hereby agree to adhere to and follow the requirements as set out above. I understand that these policies will not be considered flexible without the prior consideration and permission of Stephanie Moore, PsyD and with an additional signed agreement between Dr. Moore and me.

DATE: _____PATIENT'S SIGNATURE: _____

DATE: _____ WITNESSED: _____

Stephanie Moore, PsyD, FACPN
doctorstephaniemoore.com

Request for Confidential Handling of Health Information, Consent for a Neuropsychological Assessment, Authorization to bill insurance, understanding ultimate responsibility for payment resides with the Examinee and/or Patient.

1. I _____ authorize and request that Stephanie Moore, PsyD, ABN licensed Psychologist, carry out a psychological/neuropsychological evaluation and/or diagnostic procedure, which now or during the course of my care as a patient, is advisable. I also understand that the purpose of these procedures will be explained to me and be subject to my agreement.

I have read and fully understand the consent form.

_____
(Signature) (Date)

_____
(Witness Signature) (Date)

2. I, _____ request that
(Print First and Last Name of patient/recipient)

Stephanie Moore, PsyD handle my confidential health information in the following way:

3. Please describe means by which you prefer to receive your health information or circle the methods you approve of below:

US mail, telephone call, email, fax, encrypted email, *and/or other*: _____

All reasonable requests to receive communication of your health information by alternative means will be granted.

B. I hereby assign Stephanie Moore, PsyD all payments for medical services rendered to me or my dependents. I understand that I am fully responsible for any outstanding balance regardless of my insurance coverage.

_____
(Signature) (Date)

AUTHORIZATION OF PROTECTED INFORMATION

1. I authorize my psychologist, Stephanie Moore, PsyD, FACPN and/or her administrative and clinical staff to release (**circle**): **Records** and/or **Neuropsychological Evaluation**. This information should only be released to:
Family: _____

Physicians: _____

2. I am requesting my psychologist to release this information for the following reasons, and subject to the following limitations: ("At the request of the individual" is all that is required from the patient if he/she does not desire to state a specific purpose.)

Circle: At my request or other reason: _____

3. This authorization shall remain in effect. *Circle either*:
Until a specific date: _____ or Dr. Moore is **notified by Mail**.

4. I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to my psychologist's office address. However, my revocation or modification will not be effective until my psychologist receives it.

5. I understand that my psychologist generally may not condition psychological services upon my signing an authorization that would allow a disclosure of PHI that is not permitted as described in Sections I through III of the Notice form provided by my psychologist, or a disclosure that is otherwise not permitted by law. I understand that even if the authorization would not involve impermissible disclosures, my psychologist may not condition treatment upon my signing an authorization unless: 1) my treatment is related to research and the authorization is to allow the use or disclosure of PHI for that research; or 2) the psychological services are provided to me for the purpose of creating health information for a third party.

6. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule.

7. Normal email communication with Dr. Moore and Ruth Lange is **not** encrypted.

_____ _____
Signature of Patient Date

(If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.)

A XEROX COPY OF THIS FORM SHALL BE AS VALID AS THE ORIGINAL

ADULT NEUROPSYCHOLOGICAL HISTORY

Name: _____ Date: _____

Address (Street, City, Zip): _____

Examinee's Telephone Number: (H):_____ W): _____

Age: _____ Date of Birth: _____ Sex: ____ Years of Education: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Ethnic/Racial Background: _____ Religion: _____

Place of Birth: _____

Name of Referring Physician, Friend: _____

Briefly describe your problem _____

_____

_____

What specific questions would you like answered by this evaluation?

1._____

2._____

3._____

This form has been completed by: _____

If not completed by the examinee, please provide the following information:

Name: _____ Relationship to Examinee: _____

Address: _____

Telephone Number: (H) _____ (W) _____

DEVELOPMENTAL HISTORY

4. You were born: on time ___ prematurely ___ late ___
5. Your weight at birth: ___ pounds ____ ounces

6. Mother's weight during pregnancy: ___ pounds

7. Were there any problems associated with your birth (such as oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (i.e., need for oxygen, special equipment used, convulsions, illness, etc.). Yes ___ No ___

If "yes" describe: _____

8. Check all that applied to your mother while she was pregnant with you:

___ Accident
___ Alcohol use
___ Cigarette smoking
___ Drug use (marijuana, speed, cocaine, LSD, etc.).
___ Flu/Influenza
___ Illness (toxemia, diabetes, high blood pressure, infection, Rh incompatibility)
___ Poor nutrition
___ Psychological problems (depression, mania, Schizophrenia, etc.)
___ Other problems: _____

9. List all medications prescribed or over the counter that your mother took while pregnant with you: _____

10. During her pregnancy, did your mother live near a polluted area (toxic waste dump) or other hazardous area (nuclear plant, industrial area, pesticide sprayed area)?

11. Rate your developmental progress as it has been reported to you by checking one:

	Early	Average	On time
Walking			
Language			
Toilet Training			
Overall Development			

12. ***As a child*** did you have any of these conditions? If so, circle the condition.

Attention Problems	Head Injury	Muscle Tightness/weakness
Clumsiness	Hearing Problems	Speech Problems
Developmental Delay	Hyperactivity	Vision Problems
Frequent Ear Infections	Learning Disability	Loss of Consciousness

Other problems? _____

PAST MEDICAL HISTORY

13. Circle all conditions diagnosed ***when you were a child*** and indicate age, treatment provided and any other pertinent information:

Allergies	Epilepsy or Seizure	Pneumonia
Asthma	Fevers (104 F or higher)	Poisoning
Brain Infection/Disease	Heart Problems	Polio
Cancer	Immune System Disease	Rheumatic Fever
Cerebral Palsy	Kidney Problems	Scarlet Fever
Chicken Pox	Lung (respiratory) Disease	Tuberculosis
Colds (excessive)	Measles	Venereal Disease
Diabetes	Meningitis	Whooping Cough
Encephalitis	Oxygen Deprivation	
Other:		

14. As a child, were you exposed to excessive amounts of lead (e.g. Eating paint chips, living next to high concentrations of automobile exhaust fumes) or other toxic agents? Circle: Yes/No

If "yes" please explain: _____

15. As a child did you ever have an accident that required a hospital visit? Circle: Yes/No

If "yes" please describe: _____

16. List all medications that were regularly given to you as a child:

Medication	Reason for the Medication
_____	_____
_____	_____
_____	_____

CURRENT MEDICAL HISTORY

*17. Circle all that **currently** apply*

AIDS, ARC, HIV+	Heart disease	Parkinson's disease
Allergies	Huntington's disease	Polio
Arteriosclerosis	High blood pressure	Psychiatric problems
Arthritis	Kidney disease	Radiation exposure
Blood disorder	Liver disease	Senility (dementia)
Brain disease/infection	Lung/respiratory disease	Stroke/ TIAs
Cancer or chemotherapy	Malnutrition	Thyroid disease
Diabetes	Meningitis	Venereal disease
Hazardous/Toxic exposure	Multiple sclerosis	Incontinence

Any other problems: _____

18. List all medications, over-the-counter drugs or herbs that you currently take, including the dosage and any side effects.

Please include both prescription and over-the-counter medications:

Medications	Dosage	Side-Effects

Do you take the medications as prescribed: circle YES or NO?

19. Do you have epilepsy or a seizure disorder: circle YES or NO

If "YES" circle the type with which you have been diagnosed:

PARTIAL	GENERALIZED	UNCLASSIFIED TYPE
Simple, partial (Jacksonian)	Absence (Petit Mal)	
Complex Partial (psychomotor)	Myoclonic	
Partial evolving into generalized	Clonic	
	Tonic-clonic (grand mal)	
	Atonic	

If you have seizures and do not know what type, please describe them: _____
_____

20. Have you ever experienced a head injury: circle YES or NO. Describe the circumstances and any problems you had afterwards: _____
_____

Were you in a coma? Circle *YES* or *NO*. How long: _____?

Last clear memory prior to injury: _____?

First continuous memory after injury: _____?

21. Describe all hospitalizations you have had:

a. _____

b. _____

c. _____

FAMILY HISTORY
The following questions deal with your biological mother, father, brothers, sisters:

MOTHER

22. If she is alive, what is her present age: _____?

23. If deceased, her cause of death was: _____at age: _____?

24. Has she ever had memory impairment _____?

25. Mother's level of education: _____?

26. Mother's occupation _____?

27. Does your mother have a known or suspected learning disability: circle **YES** or **NO**.

28. Describe your mother's health history:
_____

FATHER

29. If he is alive, what is his present age: _____? If deceased, his cause of death was: _____ at age: _____?

30. Did your father ever have memory impairment? _____?

31. Father's occupation __ _____?

32. Father's level of education: _____?

33. 34. Does your father have a known or suspected learning disability? **YES** or **NO**.

34. Describe your father's health history:
_____

35. What were the ages of your Mother: _____ Father: _____when you were born?

37. Who raised you: (Check all who apply and at what ages)

Biological parent (s)	Relatives	Foster parents
Biological and stepparent	Adoptive parents	Institution
Others:		

36. What languages were spoken at home: Primary: ____ Secondary: ____

SIBLINGS:
37. How many brothers _____ and sisters _____ do you have?

38. Where are you in the birth order?

39. Are there any unusual problems (physical, academic, psychological) associated with any of your siblings? Circle YES or NO. If "YES" please describe:
_____

40. Please check all that existed in close biological family members (parents, brothers, sisters, grandparents, aunts, uncles).

	WHO	DESCRIBE
Epilepsy		
Learning Disability		
Left-handedness		
Mental Retardation		
Speech/Language Disorder		
Auto-immune Disorder		
Other major disease/disorder		
NEUROLOGIC DISEASE		
Alzheimer's disease/senility		
Huntington's disease		
Parkinson's disease		
Multiple Sclerosis		
ALS/ Lou Gehrig's Disease		
Down's Syndrome		
Other neurologic disease		
PSYCHIATRIC ILLNESS		
Alcoholism		
Manic Depressive/Bipolar		
Depression		
Personality disorder		
Schizophrenic		
Criminal/Violent Behavior		
Other psychological Illness		

PERSONAL HISTORY
Marital History:

41. Current status: Married___ Single ___ Divorced___ Widowed ____ Separated ____
42. Years married to current spouse: _____ 45. Number of times married: _____
43. If married, spouse's name: _____ Spouse's age: _____
44. Spouse's occupation: _____

45. Spouse's health: Excellent ____ Good ____ Poor ____

46. Not married, but living with someone: Yes ____ No ____

His/her health: Excellent ____ Good ____ Poor ____
His/her occupation: _____

47. Names and ages of children:

Educational History
48. Highest grade completed or highest degree earned: _____
Name of school in which education was received: _____

49. How would you describe your usual performance as a student?

A & B	*Please describe any helpful information*:
B & C	
C & D	
D & F	

50. Did you ever repeat a grade? Circle YES or NO. If "YES" what grade and for what reason? _____

51. Were you ever in any special classes or receive special education services: Circle YES or NO
IF "YES" what grade ____ or age: ____ and what type of service: _____?

52. Were you ever suspended or expelled from school: YES or NO. If so, please explain:
_____

Occupational History
53. Current job title:
54. Salary: under $10,000___ $10,000-29,999___, $30,000-50,000___, over $50,000___
55. How long have you been at this job? _____
56. Current job responsibilities _____
57. List prior jobs, starting with the most recent:

POSITION	*LENGTH OF TIME ON THIS JOB*

58. At any time while on the job, were you exposed to hazardous or noxious substances (e.g., lead, mercury, asbestos, radiation, solvents, pesticides, chemicals)? **YES** or **NO**. If "YES" please explain: _____

Military History

59. Branch: _____
60. Discharge rank: _____ Type of discharge: _____

61. Major military duties: _____

62. List any physical injuries you had during military service: _____

63. Were you exposed to any dangerous substances while in the military (e.g., Agent Orange, radiation, etc.)? Explain: _____

Recreation

64. List the types of recreation that you enjoy (i.e., sports, games, TV, hobbies, etc.): _____

Substance use history
<u>Alcohol</u>
65. I started drinking at age: _____

66. I drink alcohol: Rarely/never ____ 1-2 days/week ____ 3-5 days/week ___ Daily ___

67. I used to drink but stopped on: date stopped _____

68. Preferred type (s) of drinks: _____

69. Usual number of drinks I have at a time: _____

70. My last drink was less than 24 hours ago ___ 24-48 hours ___ over 48 hours ____

71. Check all that apply:
___ I can drink more than most people at my age and size before I get drunk.
___ I sometimes get into trouble (fights, legal difficulties, problems at work, conflicts with family, accidents, etc.) after drinking.
___ I sometimes black out after drinking.
___ I sometimes drink in the morning.
___ I have had a DUI

Cigarettes
72. I started smoking at age: _____ Stopped at age: _____

73. I currently smoke _____ cigarettes each day.

Drugs
74. Please check all the drugs you are currently using or have used in the past:

	FROM	AMOUNTS CONSUMED	FREQUENCY
Amphetamines			
Barbiturates			
Cocaine/Crack			
Hallucinogens			
Inhalants			
Marijuana			
Opiates			
PCP			

Please list all other drugs used: _____

75. Do you consider yourself dependent on any of the above drugs: YES or NO

76. Do you consider yourself dependent on any prescription drugs? YES or NO. Which prescription drugs: _____

77. Check all that apply:
____ I have gone through drug withdrawal
____ I have used I.V. drugs
____ I have been in drug treatment. Year: _____ Where: _____

Legal and Suicide History

78. Legal difficulties: (i.e., arrests, restraining orders, property damage, law suits, DUIs, etc.): _____

79. Family or personal history of suicidal behavior: *YES* or *NO*
Suicide attempts: When _____ Describe _____
Suicidal Ideation/threat: When _____ Describe _____

Do you have suicidal thoughts now? *YES* or *NO*

80. Have you ever physically assaulted another person *YES* or *NO*. If "*YES*" please describe: _____

81. Please list any recent stressors you have experienced (i.e., death of a loved one, divorce, unemployment, pregnancy, retirement, change of residence, etc.) _____
_____

Medical Testing

82. Check all the medical tests that have recently been completed and state any abnormal results:

TEST	ABNORMAL FINDINGS
Angiography	
Blood work	
Brain scan	
CT scan	
EEG	
Lumbar puncture/spinal tap	
MRI	
Neurological office exam	
PET scan	
Physician's office exam	
Skull x-ray	
Ultrasound	
Other testing results:	

83. Identify the physician who is most familiar with your recent problems:
Name: _____
Address; _____
Telephone: _____
Date of your last medical check-up: _____
Findings at check-up: _____

84. Have you had a prior psychological or neuropsychological evaluation YES or NO
Name of psychologist: _____
Address; _____
Telephone: _____
Date and reason for evaluation: _____
Findings of evaluation: _____

85. Have you had psychological treatment YES or NO? If "YES"
Name of therapist: _____
Address; _____
Telephone: _____
Dates of treatment and reason for evaluation: _____

REVIEW OF SYSTEMS

Constitutional Symptoms
- ☐ Good General Health today
- ☐ Recent Weight Change (Circle loss/gain)
- ☐ Fever/Chills
- ☐ Chronic Fatigue
- ☐ Fever

Eyes
- ☐ Eye Disease/Injury/Blindness
- ☐ Wear Glasses/Contact Lenses
- ☐ Blurred, Dizziness or Double Vision
- ☐ Glaucoma

Ears, Nose, Mouth, Throat
- ☐ Hearing Tones or Ringing (circle correct one)
- ☐ Hearing Loss
- ☐ Chronic sinus problem or tinnitus
- ☐ Nose bleeds
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Bad Breath or Bad Taste
- ☐ Voice Change
- ☐ Swollen neck glands

Cardiovascular
- ☐ Heart Trouble
- ☐ Chest pain or Angina Pectoris
- ☐ Palpitations
- ☐ Shortness of Breath w/ walking/lying flat
- ☐ Swelling of Feet or Ankles

Respiratory
- ☐ Chronic or Frequent Coughs
- ☐ Spitting up Blood
- ☐ Shortness of Breath
- ☐ Asthma or Wheezing (circle correct answer)

Gastrointestinal
- ☐ Loss of Appetite
- ☐ Change in Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Reflux Disease
- ☐ Constipation
- ☐ Bleeding or Blood in Stool
- ☐ Abnormal Pain or Heartburn
- ☐ Peptic Ulcer (stomach or duodenal)

Genitourinary
- ☐ Incontinence
- ☐ Kidney Stones
- ☐ Sexual Difficulties
- ☐ Pregnancy Difficulties
- ☐ Irregular Periods

Thank you for filling out this lengthy form

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Stiffness or Swelling
- ☐ Weakness of Muscles or Joints
- ☐ Muscle Pain or Cramps
- ☐ Back Pain
- ☐ Cold Extremities
- ☐ Difficulty Walking

Skin
- ☐ Rash or Itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Varicose Veins
- ☐ Breast Pain or Lump
- ☐ Breast Discharge

Neurological
- ☐ Problems with Sleep
- ☐ Frequent or Recurring Headaches or Migraines
- ☐ Light-headed or dizzy
- ☐ Convulsions or Seizures
- ☐ Numbness or tingling sensation (arms/legs/face)
- ☐ Tremors
- ☐ Paralysis
- ☐ Stroke, Meningitis, Encephalitis, Seizure
- ☐ Head Injury
- ☐ Frequent Falls
- ☐ Sensitivity to bright lights or noise (circle)

Neurop**sychiatric**
- ☐ Nervousness or Anxiety (circle correct answer)
- ☐ Depression, Nervous Breakdown
- ☐ Insomnia
- ☐ Word-Finding Difficulty
- ☐ Problems with Attention/Concentration
- ☐ Memory Loss or Confusion

Endocrine
- ☐ Heat or Cold Intolerance
- ☐ Skin Becoming Drier
- ☐ Change in Hat or Glove Size
- ☐ Glandular or Hormonal Problems
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Excessive Thirst or Urination

Hematological/Lymphatic
- ☐ Slow to Heal Cuts
- ☐ Anemia
- ☐ Phlebitis
- ☐ Blood Transfusion
- ☐ Enlarged Glands
- ☐ Tendency to Bleed or Bruise Easily (circle)