INTEGRA PSYCHOLOGICAL SERVICES

611 S State Hwy 78 #122
Wylie, TX 75098
P: 972-442-0605
F: 972-215-7150
E: appointments@integrapsych.com

Levi Armstrong, PsyD, MSCP
Clinical Neuropsychologist

Maria Lippart, PsyD
Clinical Neuropsychologist

NEW PATIENT - PRACTICE POLICY ACKNOWLEDGEMENT FORM

Patient Name:_____ DOB:_____ Age:_____

Biological Sex:_____ Gender Pronouns: _____ Ethnicity:_____ Handedness: R L Both

Primary Language Spoken: _____ Other Languages Spoken:_____

Current Grade (or highest degree earned) & SCHOOL DISTRICT:_____

Physical Address (City, State, Zip):_____

Phone Number (where scheduling & billing questions can be directed):_____
May We Leave a Voicemail? ☐ *Yes* ☐ *No* *Do You Consent to Text/Voicemail Appointment Reminders?* ☐ *Yes* ☐ *No*

Billing Address (where billing statements can be mailed):_____

Legal Guardian(s) Name (if applicable):_____

How Did You Hear About Us? _____

Who Referred the Patient to Us? _____

At the time of your feedback/follow-up to review the evaluation results with the doctor, you will be provided a finalized report via an online HIPPA compliant, secure link which will allow you to download a PDF version of the report. Please provide us the email to which you would prefer this link to be emailed. If you need results sooner than 6 weeks sent to a treatment provider, please provide us the clinician's first and last name, their specialty area (e.g., psychiatrist), their fax and phone numbers, and the date and time of the patient's next appointment so we can ensure that a summary of the patient's results are sent to them in time for your next appointment. By checking the box below, you are confirming that you are aware that it may take the doctor up to 2 weeks after your follow-up / feedback appointment to send you the secure link:

☐ YES, I UNDERSTAND AND HAVE READ THE ABOVE INFORMATION

EMAIL ADDRESS TO WHICH YOU WANT THE SECURE LINK EMAILED:_____

Please Provide the First/Last Names and Contact Information for the Patient's Treatment Providers to Whom We Need to Send an <u>Evaluation Results Summary</u> Prior to You Receiving the Final Report

Provider's Name/Contact Information: _____

Treatment Provider's Phone #: _____ Fax #:_____

Date and Time of the Patient's Next Appointment: _____

PATIENT OR GUARDIAN SIGNATURE & DATE:_____ DATE:_____

***** Your signature above confirms your acknowledgement that you have read the above information, insurance assignment and release, practice disclosure statements, policies on our fees and use of third-party payors (e.g., insurance), limits of confidentiality, notice of privacy practices/rights to privacy, and have had the opportunity to discuss the contents with us. By signing above, you are also attesting that you consent to treatment by Dr. Levi Armstrong and/or his clinical staff at Integra Psychological Services, PLLC with the knowledge of the above conditions.

PATIENT HEALTH INSURANCE INFORMATION

Primary Name on Policy:_____ Primary Policy Holder DOB:_____

Policy Holder's Address (if different from above):_____

Policy Holder's Phone: _____ Email of Policy Holder:_____

Insurance Carrier:_____ Insurance ID / Policy #_____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Primary Name on Policy:_____ Primary Policy Holder DOB:_____

Policy Holder's Address (if different from above):_____

Policy Holder's Phone: _____ Email of Policy Holder:_____

Insurance Carrier:_____ Insurance ID / Policy #_____

CREDIT CARD INFORMATION

By signing page 1 of this document, you agree to have your credit card information stored by Integra Psychological Services, PLLC until your file has been closed. You also authorize Integra Psychological Services, PLLC to charge your credit card for any outstanding financial responsibilities such as copayments, coinsurance, no show/late cancellation fees and deductible payments. NOTE: Patients will be contacted prior to charging their card. Insurance does not cover any cancellation/no-show fee. If you are unable to keep your appointment for any reason, you must give 24 hours advance notice. We will also accept cash and checks for payments prior to services. **Please complete the credit card information section below as this information is required prior to any appointment can be scheduled.**

Name as it appears on credit card: _____

Card Type (Circle One): Visa MasterCard American Express Other:_____

Card Number: _____ Expiration Date:_____ 3-Digit Code:_____

Billing Address Including Zip Code:_____

ASSIGNMENT / RELEASE / DISCLOSURE / CONSENT TO TREATMENT

My signature on the first page of this document certifies that I, the patient, or my dependent or guardian has insurance coverage with the above listed insurance carrier and assign directly to Integra Psychological Services, PLLC and/or Levi Armstrong, Psy.D., MSCP all insurance benefits, if any, for all agreed-upon services rendered at Integra Psychological Services, PLLC. The signature on the first page of this document attests to my understanding that I am financially responsible for all charges per contractual reimbursement schedules between Dr. Armstrong and your insurance carrier (even if the insurance carrier does not cover some or any of the services provided). I hereby authorize the administrative and/or clinical staff of Integra Psychological Services, PLLC and/or Levi Armstrong, Psy.D., MSCP to release all information necessary (including diagnoses, mental health records and substance abuse records) to my insurance carrier and/or other third-party payors in order to secure payment of benefits. I authorize the use of this signature on all insurance submissions. By signing the previous page of this document, I acknowledge that I (or the patient), or my referring party, have requested neuropsychological testing, psychological testing, counseling, neurofeedback, and/or consultation/psychological treatment from clinical neuropsychologist Dr. Levi Armstrong and/or the clinical staff at Integra Psychological Services, PLLC. As a licensed psychologist licensed to practice in the State of Texas, there are regulations that you can review regarding our practice and resources available to you under the licensing act. This disclosure statement is a part of those resources. As a patient you have the right to refuse any suggested treatment and the freedom to choose the psychologist and treatment best suited to your needs. You also have the right to request a change of therapy, referral to another psychologist/therapist, or to discontinue an evaluation and/or treatment at any time. This document also serves as a notice to the risks and benefits of participating in psychological services. Some of the potential risks involved in being provided psychological services include discovering psychological/neuropsychological aspects about yourself that you may find uncomfortable, as well as the potential that the evaluation in which you participate does not yield the results you would prefer, or your medical records being disclosed to third parties should your records be requested upon a court order signed by a judge. Should you have any complaints regarding our services provided, we would encourage you to speak with Dr. Armstrong regarding these matters. If this does not resolve your concerns, you are also welcomed to contact the Texas State Board of Examiners of Psychologists at the following contact information:

Texas State Board of Examiners of Psychologists
333 Guadalupe
Tower 2, Room 450
Austin, Texas 78701
1-800-821-3205

PATIENT FEE / POLICY AGREEMENT FORM

REGARDING SERVICES & CLINICAL TIME THAT CANNOT BE BILLED TO INSURANCE

The purpose of this form is to inform all patients of our policies and fee schedule for services rendered, administrative staff time spent fulfilling requests, and completion of and/or participation in non-medically necessary tasks. Below are services which are unfortunately considered **NOT medically necessary** by health insurance payors and therefore cannot be billed to your insurance as a component of the neuropsychological and/or a psychological evaluation or corresponding medically necessary services. Thus, the following fees are assessed for requested services below and are expected to be paid in full at the time of the service:

Completion of 504 / ARD / IEP / College documentation forms for accommodations and modifications
FEE FOR THIS SERVICE: $50.00

Completion of short-term, long-term, and/or social security disability forms
FEE FOR THIS SERVICE: $150.00

Provision of notes, letters, and/or completion of official forms for housing or travel accommodations for pets, etc.
FEE FOR THIS SERVICE: $250.00

Participation in 504/ARD/IEP meetings (virtual only)
FEE FOR THIS SERVICE: $50.00 per 15 minutes (15 min. minimum)

Request for additional feedback appointments and/or future general consultative visits
FEE FOR THIS SERVICE: $300.00 per 60 minutes (1 hour appointment minimum)

Requests for Dr. Armstrong's participation, consultation, and/or any additional time, testimony, depositions, etc. or services in relation to any legal proceedings (civil or criminal) unless a prior expert witness agreement form has been already completed and signed by both Dr. Armstrong and the retaining party(ies).

*FEE FOR THIS SERVICE: $500.00 per hour (port-to-port) / $2,000 for mandatory minimum
Mandatory minimum of 8 hours is billed ($2,000/day) and must be pre-paid in order to schedule
Any time required of Dr. Armstrong beyond the mandatory minimum is billed at $500 per hour in 15 min increments
No refunds for rescheduled, delayed, or cancelled court hearings/dates
Mandatory minimum ($2,000) must be paid before the date of the hearing/court date

By signing below, you agree to and give staff at Integra permission to receive payment from you directly. Payment(s) must be made prior to or at the time of the service being provided. Payment can be made via credit card, cash, check, or money order.

Patient Name (Print):_____ Guardian (if applicable): _____

Patient/Guardian Signature: _____ Date: _____

AUTHORIZATION FOR DISCLOSURE & RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____ Last 4 of Social Sec. #_____

Patient or Guardian Signature: _____ Today's Date (date of authorization): _____

Guardian #2 (if required – see below) Printed Name: _____

Guardian #2 (if required – see below) Signature: _____

Note: Parents of minors who are divorced will need BOTH parents to sign ALL pertinent forms prior to treatment OR the parent requesting the evaluation must provide a copy of the divorce decree indicating their right to consent to treatment for their child.

My signature above authorizes the clinical staff at Integra Psychological Services, PLLC to use professional judgment in deciding what specific information will be released and communicated and whether specific records should be disclosed or whether a summary of treatment should be disclosed instead of specific records. I understand that any treatment records concerning my medical / psychological / mental health treatment are confidential under Texas law (unless ordered by a court of law), and that a statutory privilege prohibits confidential treatment information from being disclosed without my consent. This authorization may be revoked at any time, except to the extent that information has already been released. If not revoked, it shall terminate one year from the date of authorization.

I also authorize Levi Armstrong, Psy.D., MSCP and/or the clinical staff at Integra Psychological Services, PLLC to disclose and receive in both written and verbal communication the confidential medical and psychological records/information concerning the above listed patient to the identified person(s)/agencies to be named below:

Please provide the first and last name (and specialty treatment area if a treating provider) for anyone to whom you give us permission to release your records.

1. Name of Person or Agency _____

Phone and Fax Number: _____

2. Name of Person or Agency _____

Phone and Fax Number: _____

3. Name of Person or Agency _____

Phone and Fax Number: _____

4. Name of Person or Agency _____

Phone and Fax Number: _____

5. Name of Person or Agency _____

Phone and Fax Number: _____

Release of information will be valid for one year from the date of authorization noted above unless otherwise terminated with written request from the patient or legal guardian.

PATIENT OR GUARDIAN SIGNATURE & DATE: _____ DATE: _____

LIMITS OF CONFIDENTIALITY / NOTICE OF PRIVACY PRACTICES & PRIVACY RIGHTS

Limits of Confidentiality: Information discussed in the neuropsychological or psychological evaluation will be incorporated into a neuropsychological (or psychological) evaluation report. If you are participating in therapy, a detailed progress note of each session will be electronically recorded and kept securely via an electronic medical record system and/or a HIPAA-compliant cloud server. Please note that per TSBEP Acts and Rules of the Board, any handwritten therapy notes do not constitute your medical record and will not be available or disclosed to anyone unless in compliance with a court order. It is our legal and ethical duty to protect your treatment records and your records with us will remain confidential and will not be shared without your written permission. State law mandates that mental health professionals may need to break confidentiality/share your treatment records and/or report the following (a-f) to the appropriate persons or agencies. In addition, if the patient is involved in a legal action, your health records may be required to be released without your consent per a court order. All communication between your healthcare provider and you will otherwise be deemed confidential except under the following conditions:

a) The patient threatens suicide or is believed to be in imminent harm to his or herself
b) The patient threatens harm to another person(s), including murder, assault, or other physical harm.
c) The patient reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
d) The patient reports abuse of the elderly or the disabled.
e) The patient makes a threat against a government agency.
f) A court order requesting your records and with notification to you that your records will be released.

Sessions, Scheduling, & Fee's: Appointments are scheduled directly by calling 972-442-0605. Psychological and neuropsychological evaluations typically require 1-10+ hours of direct or indirect time. Psychotherapy sessions and testing follow-up appointments typically last 50 minutes. Our hourly rate ranges between $175.00 - $350 per hour for these services, although a sliding scale is also available in some circumstances. However, we will discuss your obligations up front prior to your services. If you become involved in legal proceedings that require our participation, you will be expected to pay for all professional and administrative time, including preparation and transportation costs (port-to-port), even if we are called to testify by another party. Fees for these forensic services are $500 per hour ($2,000 minimum or 4 hours).

Payment of Fees & Other Policies: You will be expected to pay for each appointment at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose your otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided and the amount due. If such legal action is necessary, its costs will be included in the claim. Timely payment and open discussion will prevent that mutually unpleasant experience. A $25 fee will be charged for any checks returned for insufficient funds. Sometimes it is necessary for us to cancel a session unexpectedly due to unforeseen circumstances such as court orders, subpoenas, personal, or professional emergencies. Whenever possible, we will make every effort to notify you in advance and reschedule your appointment.

Treatment of Minors / Policy for Patient Records Who Were Evaluated/Treated while Minors: It is the policy of this office that treatment of children under the age of 18 years will be provided only with the consent of their legal guardian or parent. By signing this consent form, you acknowledge that you are the guardian (as established by the state or an official divorce decree) of any minor presented for treatment. Copy of the custody agreement / divorce decree in the cases of divorce must be provided prior to treatment OR each legal guardian/custodial parent MUST sign a consent for treatment form prior to treatment or testing. It should also be noted that Dr. Armstrong does not specialize in non-court ordered child custody evaluations. If you are currently anticipating your need for these services, he will happily provide you with the contact information of other clinicians who specialize in these matters. All psychological records pertaining to an adult patient (age 18+), who on the date of the evaluation was less than 18 years of age, and who was seen, evaluated, or treated by Integra Psychological Services, PLLC and/or Levi Armstrong, Psy.D., MSCP are only accessible by parents, guardians, attorneys, etc. with the written consent of that now adult patient. That is, all previously signed release of records become null and void at the time of the patient's 18th birthday, and parents, guardians, attorneys, etc. will not be permitted copies of any records without written consent by the patient unless a copy of legal guardianship or medical power of attorney is provided to us.

Responding to Requests of Information: The patient and/or legal guardians and/or any third party to whom your consent is given can request copies of your medical information. Please note that there may be a fee charged in association with producing your records. Please also note that all requests of records must be provided in writing, email, or fax and that it may take up to 14 days for us to produce the records.

NOTICE OF PRIVACY PRACTICES / HIPAA: This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Understanding Your Health Information: Each time you visit a hospital, physician, or other health care provider, a record of your visit is made in order to manage the care you receive. Your healthcare provider listed on this document understands that the medical information that is recorded about you and your health is personal. The confidentiality of your health information is also protected under both state and federal law. This Notice of Privacy Practices describes how your healthcare provider may use and disclose your information and the rights that you have regarding your health information.

Your Health Information Rights: Although your health information is the physical property of the facility or practitioner that compiled it, the information belongs to you, and you have certain rights over that information. You have the right to: Request, in writing, a restriction on certain uses and disclosures of your health information. However, agreement with the request is not required by law, such as when it is determined that compliance with the restriction cannot be guaranteed; Inspect or obtain a copy of your health record as provided by law; Request, in writing, that your health record be amended as provided by law, if you feel the health information, we have about you is incorrect or incomplete. You will be notified if the request cannot be granted; Request that we communicate with you about your health information in a specific way or to a specific location. Reasonable requests will be accommodated; Obtain accounting of disclosures of your health information as provided by law; Obtain a paper copy of the Notice of Privacy on request. You may exercise these rights by directing a request to the Privacy Office Contact list on this Notice.

Our Responsibilities: Your healthcare provider has certain responsibilities regarding your health information, including the requirement to: Maintain the privacy of your health information; Provide you with this Notice that describes your healthcare providers' legal duties and privacy practices regarding the information we obtain about you; Abide by the terms of the Notice currently in effect. Your healthcare provider reserves the right to change these information privacy policies and practices and to make the changes applicable to any health information that we maintain. If changes are made, the revised Notice of Privacy Practices will be made available at our office and will be supplied when requested.

Uses and Disclosures of Health Information without Authorization: When you obtain services from your healthcare provider, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment and to support the operations of the entity and other involved providers. The following categories describe ways that your healthcare provider may use or disclose your information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

Your health information will be used for treatment: For example: Disclosures of medical information about you may be made to physicians, nurses, technicians, medical residents, or others involved in taking care of you. This information may be disclosed to other physicians who are treating you or to other health care facilities involved in your care. Information may be shared with pharmacies, laboratories or radiology centers for the coordination of different treatment.

Your health information will be used for payment: For example: Health information about you may be disclosed so that services provided to you may be billed to an insurance company or third party. Information may be provided to your health plan about treatment you are going to receive in order to obtain prior approval or to determine if your health plan will cover the treatment.

Your health information will be used for health care operations: For example: The information in your health care record may be used to evaluate and improve the quality of the care and services we provide. Students, volunteers, and trainees may have access to your health information for training and treatment purposes as they participate in continuing education, training, internships and residency programs.

Business Associates: There are some services that we provide through contracts with third-party business associates. Examples include transcription agencies and copying services. To protect your health information, your healthcare provider requires these business associates to appropriately protect your information.

Continuity of Care: To provide the continuity of your care, your information may be shared with other health care providers such as home health agencies. Information about you may be disclosed to community service agencies to obtain their services on your behalf.

Disclosures Required by Law or Otherwise Allowed Without Authorization or Notification
The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement: When a disclosure is required by federal, state, or local law, judicial or administrative proceedings or for law enforcement. Examples would be reporting gunshot wounds or child abuse, responding to court orders; For public health purposes, such as reporting information about births, deaths, and various diseases, or disclosures to the FDA regarding adverse events related to food, medication, or devices; For health oversight activities, such as audits, inspections, or licensure investigations;

To organ procurement organizations for the purpose of tissue donation or transplant; For research purposes, when the research has been approved by an institutional review board that has reviewed the research proposal and established guidelines to provide for the privacy of your health information; or the disclosure is that of a limited data set, where personal identifiers have been removed;

To coroners and funeral directors for the purpose of identification, the determination of the cause of death or to perform their duties as authorized by law; To avoid serious threat to the health or safety of a person or the public; For specific government functions, such as protection of the President of the United States; For Worker's Compensation purposes; To military command authorities as required for members of the armed forces; To correctional institutions or law enforcement officials concerning the health information of inmates, as authorized by law.

Disclosures Requiring Verbal Agreement: Unless you give notice of an objection, and in accordance with your Authorization to Verbally Release Health Information, medical information may be released to a family member or other person who is involved in your medical care or who helps pay for your care. Information about you may be disclosed to notify a family member, legally authorized representative, or other person responsible for your care about your location and general condition.
This may include disclosures of information about you to an organization assisting in a disaster relief effort, such as the American Red Cross, so that your family can be notified about your condition. You will be given an opportunity to agree or object to these disclosures except as due to your incapacity or in emergency circumstances.

Other Allowable Uses and Disclosures without Authorization: Other uses or disclosures of your health information that may be made include contacting you to provide appointment reminders for treatment or medical care, as well as to recommend treatment alternatives; Notifying you of health-related benefits and services that may be of interest to you;

Required Uses and Disclosures: Under the law we must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine compliance with federal privacy law.

Uses and Disclosures Requiring Authorization: Any other uses or disclosures of your health information not addressed in this Notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

Privacy Complaints: You have a right to file a complaint if you believe your privacy rights have been violated. This complaint may be addressed to the Privacy Contact listed in this Notice, or to the Secretary of the U.S. Department of Health & Human Services. There will be no retaliation for registering a complaint.

Privacy Contact: Address any questions about this Notice or how to exercise your privacy rights to the applicable Privacy Officer Contact listed below.

Effective Date: 08/15/2019
Last Updated: 06/01/2022

Privacy Officer Contacts
Levi Armstrong, Psy.D., MSCP
P: 972-442-0605
F: 972-215-7150

PATIENT OR GUARDIAN SIGNATURE & DATE:_____DATE:_____

PATIENT NAME:_____ **TODAY'S DATE:**_____

PATIENT DOB:_____ **PATIENT AGE:**_____

NEW PATIENT HISTORY FORM

What Questions Do You Hope to Be Answered by this Evaluation? _____

_____

What Are the Main Symptoms, Difficulties, Areas of Concern Does the Patient Have?_____

_____

When Did these Difficulties/Symptoms Begin? _____

_____

_____

How Do the Symptoms Affect the Patient's Daily Life? (e.g., work, school, relationships, etc.) _____

_____

Who Currently Lives with the Patient? (circle all that apply): Spouse/Partner Children (how many _____?)

Bio Parent(s) Single Bio Parent Bio Parent + Stepparent Adoptive Parents Siblings (how many____?)

Other:_____ In What City Does the Patient Live? _____

DEVELOPMENTAL HISTORY

Was the Patient Born on time? Yes No Unknown Mother's Age at Conception:____Father's Age at Conception:___

Patient's Weight at Birth: _____Normal Pregnancy / Delivery? Yes No Unknown

If Applicable, Please List Any Complications with the Patient's Mother's Pregnancy or Delivery:_____

_____

_____

Was the patient exposed to any of the following while in utero (circle all that apply): NONE Nicotine Alcohol Drugs

Did the patient's mother take any prescription or OTC medications or supplements during pregnancy? Yes No Unknown

If Yes, which ones? _____

Did the Patient Suffer any Major Childhood Illnesses, Injuries, or Hospitalizations? Yes No Unknown

If so, please describe: _____

Did the Patient Experience Any Delays with the Following Developmental Milestones (circle all that apply)? NONE

Sleep Training Sitting Up Crawling Walking Speech-Language Skills Fine Motor Skills Social Skills

Approximate Age 1st Word Spoken:_____Approximate Age When Patient Began to Walk:_____

Did the Patient Receive or Get Referred for Any Early Childhood Intervention (ECI) Therapies? Yes No Unknown

If Yes, Which Therapies Did the Patient Receive? (e.g., speech-language therapy, occupational therapy, physical therapy, etc.):

_____

Briefly Describe the Patient's Early Childhood Personality Style, Social Skills, and/or Behaviors (ages 0-5):_____

_____

_____

_____

During the Patient's Childhood, Any History of the Following? (circle all that apply): NONE

Walking on Toes Hand Flapping Rocking Back-and-Forth Pacing Motor Tics Vocal Tics

Repetitive Motor Movements Sensory Processing Sensitivities Defiant Behaviors Explosive Anger

Mood Regulation Difficulties Depression Anxiety Obsessions/Compulsions Social Anxiety

Rigid Adherence to Routines Poor Social Skills Fixated Interests Attention Problems Impulsivity/Hyperactivity

Lazy Eye or Crossed-Eyed Motor Coordination Problems Other Developmental Challenges?_____

_____

ACADEMIC HISTORY

Current Grade or Anticipated Grade (if on summer break):_____**School District:** _____

Highest Education (circle all that apply): Less than H.S. Diploma (last grade completed_____) GED H.S. Diploma

Some College (# of hours completed):_____ Associate's Bachelor's Master's Doctorate

If a college degree was completed, what was the major?_____

Has the Patient Ever Failed or Repeated a Grade? Yes No If Yes, which grade(s):_____

Was the Patient Ever in Gifted & Talented Programming? Yes No If Yes, which grade(s):_____

Academic Areas of Difficulty:_____

Academic Areas of Strength:_____

Grade Average in K-8th (approximate – Circle One): A's B's C's D's F's

Grade Average in High School (Circle One): A's B's C's D's F's N/A

Grade Average in College/Technical School (Circle One): A's B's C's D's F's N/A

Did/Does the Patient Receive Any of the Following While in School? (circle all that apply)

Special Education/IEP for_____ 504 Accommodations for ADHD 504 Accommodations for Dyslexia

Speech Therapy Occupational Therapy Physical Therapy 504 Accommodations for (other):_____

Did/Does the Patient Get into Trouble at School Very Often? Yes No Unknown

If Yes, for what?_____

Briefly Describe the Patient's Social Skills in School:_____

_____

MEDICAL HISTORY

CURRENTLY DIAGNOSED Medical and Mental Health Conditions:_____

_____

Surgical History (Purpose and Approximate Date): _____

_____

When was the Patient's Most Recent Physical/Well-Check? What Were the Results?_____

Any Recent Blood Labs/Tests? Yes No If yes, What Were the Results? _____

Current Height:_____Current Weight:_____Any Drug Allergies?_____

Does the Patient Have Any History of the Following? (Circle All That Apply)

Traumatic Brain Injury (TBI) Concussion Stroke Seizures Heart Rhythm Problems Diabetes

Night Terrors Recurring Nightmares Exposure to Toxic Substances Alcohol/Drug Use Chronic Pain

Liver Disease Kidney Disease Genetic Disorders Neurological Illnesses Muscle Weakness Cancer

Chemotherapy Radiation Therapy Sleep Apnea Asthma Balance Problems/Dizziness Passing Out

Brief Details for Anything Circled Above:_____

_____

Please List ALL Current Medications, OTC Medications, and Supplements

Medication Name	Dosage	When is it Taken?	Who Prescribed?

MENTAL HEALTH HISTORY

Has or Is the Patient Participating in Counseling? Yes No If Yes, When and Where:_____

_____

Any History of Inpatient Mental Health Hospitalizations or Residential Hospitalizations? Yes No

If Yes, When/Where/Why?_____

Has the Patient Ever Attempted Suicide or Engaged in Self-Harming Behaviors? Yes No

If Yes, Please Describe:_____

Has the Patient Ever Engaged in or Been Suspected of (circle one): Anorexia Bulimia None Other:_____

Has the Patient Ever Been the Victim of Abuse or Witnessed Domestic Violence: Yes No Unknown

If Yes, Please Explain: _____

Does the Patient Experience or Complain of Any of the Following (Circle all that apply): NONE

Hearing Voices Visual Hallucinations Paranoia Delusional Thinking Episodes of Increased Energy/Agitation

Decreased Need for Sleep Depressed Mood Panic Attacks Compulsive Behaviors Rapid Thoughts

SUBSTANCE USE HISTORY

Does the Patient Currently Use or Have Any History of Using Alcohol? Yes No Unknown

If Yes, When, How Often, and How Much?_____

Does the Patient Have Any History of Using Nicotine? Yes No Unknown

If Yes, When, How Often, and How Much?_____

Does the Patient Have Any History of Using Marijuana/Cannabis? Yes No Unknown

If Yes, When, How Often, and How Much?_____

Does the Patient Have Any History of Illegal Use of Stimulants? Yes No Unknown

If Yes, When, How Often, and How Much?_____

Does the Patient Have Any History of Dependence on Pain Medication? Yes No Unknown

If Yes, When, How Often, and How Much?_____

Does the Patient Have Any History of Any Other Drugs/Substances? Yes No Unknown

If Yes, What, When, How Often, and How Much?_____

FAMILY MEDICAL/MENTAL HEALTH HISTORY

Biological Mother's Medical Conditions and Mental Health Diagnoses:_____

_____

Biological Father's Medical Conditions and Mental Health Diagnoses:_____

_____

Biological Sibling's Medical and Mental Health Diagnoses:_____

_____

Any Other Family History of the Following (Circle All that Apply):

ADD/ADHD Autism/Asperger's Intellectual Disability Learning Disorders Speech Problems Anxiety
Depression Bipolar OCD Schizophrenia Seizure Disorder Brain Cancer Stroke Dementia

ADAPTIVE FUNCTIONING & INDEPENDENCE

Does the patient have any problems completing these tasks at an age-appropriate level of independence?

Dressing Personal Hygiene Eating Cooking Communicating Making Friends Reading Writing Math

Driving Managing Money Completing Chores Managing Homework Taking Medication Coping with Transitions

OTHER HISTORY

Has the Patient Ever Been Arrested? Yes No If Yes, When and For What?_____

Is the patient currently or planning to apply for Social Security Disability benefits? Yes No

Is the patient currently or planning to apply for Short-Term or Long-Term Disability benefits? Yes No

Is this Evaluation Related to a Motor Vehicle Accident for Which Insurance Has Not Settled? Yes No

Is the Patient Involved (or are there plans for involvement) in Any Civil or Criminal Proceedings? Yes No

If Yes, please explain: _____

Were You or the Patient Referred for this Evaluation by an Attorney or Court/Judge? Yes No

If Yes, please explain: _____

Are There Plans to Use (or possibly use) the Results of this Exam in Custody Hearings? Yes No

EMPLOYMENT HISTORY

Check if Not Applicable ☐

Is the Patient Currently Employed? Yes No If Yes: Part-Time Full-Time # of hours per week spent working:_____

Current Job Title / Place of Employment:_____

Average Annual Salary:_____ Any Significant Conflicts or Stressors at Work?_____

Military History (if applicable – please specific if involved in active combat, rank, and job title/duties):_____

_____

NEW PATIENT CURRENT SYMPTOM SURVEY

DOES THE PATIENT HAVE ANY DIFFICULTIES IN THE FOLLOWING AREAS? PLEASE EXPLAIN

Please Check "None" if No Problems are Present

Attention/Concentration: _____ None ☐

Processing Speed: _____ None ☐

Short-Term Memory: _____ None ☐

Long-Term Memory: _____ None ☐

Speech or Language: _____ None ☐

Academic Skills: _____ None ☐

Planning/Prioritizing/Organizing: _____ None ☐

Taking Initiative: _____ None ☐

Finishing Tasks: _____ None ☐

Thinking Flexibly: _____ None ☐

Emotional Regulation _____ None ☐

Self-Awareness: _____ None ☐

Mood / Sadness / Depression / Irritability: _____ None ☐

Suicidal Thoughts: _____ None ☐

Anxiety/Worry: _____ None ☐

Obsessions/Compulsions: _____ None ☐

Social Skills: _____ None ☐

Making/Keeping Friends: _____ None ☐

Hallucinations/Paranoia/Delusions: _____ None ☐

Physical Pain / Headaches: _____ None ☐

Energy Level Most Days: _____ None ☐

Sleep: _____ None ☐

Appetite: _____ None ☐

Fine Motor Coordination or Tremor: _____ None ☐

Balance / Passing Out / Dizziness: _____ None ☐

Numbness / Tingling / Muscle Weakness: _____ None ☐

Vision/Hearing/Smelling: _____ None ☐

Heart Rhythm or Breathing Problems: _____ None ☐