NeuroBehavioral Associates, LLC

Assessment & Intervention for Neurological & Psychiatric Conditions

Adult Patient Information Today's Date_____________ _______________

Patient's Full Name__________________ ____________________ Date of Birth____________________________

SSN____ Marital Status____________ Gender ___ Male ___Female

Home Phone__________________________________ Cell Phone____

Home Address: ____

City_________________________________ State____________________ Zip_______________________

Employment____ Phone:____________________________

____Employed ____Student ____Retired ____Unemployed ____Disabled

____

Primary Insrance:____

Policy Number_________________________________ Group Number_______________________________________

Policy Holder_________________________________ Relationship_______________________________________

Policy Holder SSN____________________________ Policy Holder DOB_________________________________

Policy Holder Employment____

____

Secondary Insurance ____

Secondary Insurance ____

Policy Number________________________________ Group Number_______________________________________

Policy Holder________________________________ Relationship_______________________________________

Policy Holder SSN____________________________ Policy Holder DOB_________________________________

Policy Holder Employment____

Financial Agreement

Mental health benefits are similar to insurance benefits. Each insurance company makes its own decisions related to diagnosis covered, amount of reimbursement, for specific services and what it seems necessary in terms of diagnostic procedures and testing. In fact, you made your own decisions about the type of coverage when you made choices about deductibles and copay amounts. Neurobehavioral Associates works diligently to work with you and your insurance company to maximize the use of your available funds. We will always provide detailed information about which recommended services are covered by your insurance and which services are not, to the best of our ability.

It is important for you to understand that we are required to provide diagnostic codes and clinical information to insurance companies for you to be eligible for coverage of services related to that diagnosis. This diagnosis then becomes part of your permanent medical record. Some patients choose not to use insurance to cover our services in order to avoid the necessity of filing documentation of any psychological diagnosis. These are your decisions and we will do everything we can to make our services affordable no matter what you decide.

Full payment is due at the time services are rendered. As a courtesy, we may file your insurance, but you will be responsible for the full fee. If the session is longer than 45-60 minutes you may be billed for the additional time in 10-15-minute increments. If neuropsychological or psychological testing takes longer than the time allotted by insurance due to the complexity of your case, you will be responsible for any balance owed. If your case required an affidavit, report, or if we need to consult with an attorney and/or guardian ad litem, we will charge for the time required to compete the task. A charge will be made based on the amount if time required for this service. Insurance will not cover services other than office visits between the client and the therapist. We will bill for all the time involved for phone calls to the client, family, or other testing or consulting individuals or written information to all individual involved., Time in court is also billed at a higher rate than therapy sessions as it requires preparation and is a different service.

Payment is expect at each session. There will be a fee charged for missed appointment and a late cancelation. We reserve the right to turn over any uncollected debt (over 60 days) to a collection agency and/or magistrate court. Insurance does not cover these type of services. If you have an outstanding balance greater than $45.00, we reserve the right to refuse scheduling another appointment until payment is received. If a collections agency becomes involved, you will be responsible for all associated fees. Additionally, workman’s compensation and forensics no shows will incur the full fee of $331/hour. If workman’s compensation or attorney does not pay on the claim you will be held personally responsible. We will charge a credit card on file for all missed appointment balances greater than $45.00. Our patients will be notified 24 hours prior to any charges via phone call. Payment plans will be available upon request.

Appointment Cancelation Policy: You will be charged a fee of ($45 for therapy, $100 for intake evaluation, $300 for psychological or neuropsychological testing) if you do not provide 24-hour notice of a cancelation. Insurance companies do not cover appointments that are not kept.
By signing this agreement, you are agreeing to pay for any services which are not covered by your insurance at the time the services are rendered. You are authorizing Neurobehavioral Associates to charge the card provided below for any account balances which include, but are not limited to, co pays, co-insurance, and written telephone correspondence. Neurobehavioral Associates reserves the right to discontinue services If any unpaid balance are not paid within 60 days. Please note that the card provided must be a credit card to avoid problems related to nonsufficient fund transactions.

Name as it appears on card_______________________________________ Visa Mastercard Amex Discover

Card Number____ Expiration Date_______ Security Code______

Patient Name____ DOB_______________

Patient/Guarantor Signature____ Date_______________

Staff signature____ Date________________

Guarantor Responsible for Bills ______ Self or
Name____ Relationship____
Phone number___________________________________ Alt number____
Address (if different) ____
City____ State_______________ Zip_________________________

Please read and sign the following agreement of benefits and financial reasonability
The undersigned hereby authorize the release of information relating to all clams for benefits submitted on behalf of myself or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician or his contracted entity to submit claims for my benefit for services rendered, without obtaining my signature on each and every claim and that I will be bound by this signature as though the undersigned had personally signed the particular claim.
Payments/copays are due at the time of service. I understand that I am financially responsible for any balance on this account.
Responsible Party (Print Name) ____
Signature____

If you are related to an accident or Workers Compensation, responsible party must provide all information to the office

Yearly HIPPA Update
I hereby state that I have received the HIPPA policy of Neurobehavioral Associates either today or at a previous appointment. I hereby state that there are no changes to my HIPPA authorization. This authorization shall remain for 1 year form this date, at a minimum.
Patient____ Date________________________

Background Questionnaire- Adult

The following is a detailed questionnaire on your development, medical history and current functioning at home and at work. This information will be integrated with the diagnostic clinical interview and testing results in order to provide a better picture of your abilities as well as problem areas.
Please fill out the questionnaire to the best of your abilities.

Identifying information

Client's name____ Date________________________

If not the client, name of person completing the form _________________________________ Relationship________________

Home Address____

Work Address____

Phone Number____ Alt Phone__________________________________

Date of Birth_____________________________ Age:____________________ Sex _______Male _______Female

Primary Language_________________________ Secondary Language_______________________ Fluent/Not Fluent (circle)

Religion/Spiritual Belief____ Race/Ethnicity______________________________

Hand used for writing ____Right ____Left

Medical Diagnosis (if any) (1)____________________________________ (2)____

At this time, would you say your health is: Excellent, Very Good, Good, Fair or Poor? __________________________________

Reason for Referral

Who Referred you for this evaluation? ____

Referral Source Information____

Briefly describe the problem____

____

____

Date of Accident, injury, or onset____

Are there specific questions you would like answered by this evaluation?____

____

____

____

Current Complaints

For each symptoms that applies, place a check mark in the box. Add comments as needed

Physical Concerns

	Right	Left	Both	Date of onset
Motor	________	________	________	________________________
Headaches	________	________	________	________________________
Dizziness	________	________	________	________________________
Nausea or vomiting	________	________	________	________________________
Excessive fatigue	________	________	________	________________________
Urinary incontinence	________	________	________	________________________
Bowel Problems	________	________	________	________________________
Problems w/ fine motor control	________	________	________	________________________
Tremor or shakiness	________	________	________	________________________
Ticks/strange movement	________	________	________	________________________
Balance problems	________	________	________	________________________
Often bump into things	________	________	________	________________________
Blackout spells (fainting)	________	________	________	________________________

Other____

Sensory

	Right	Left	Both	Date of onset
Loss of feeling/numbness	________	________	________	________________________
Tingling-strange skin sensations	________	________	________	________________________
Difficulty telling hot to cold	________	________	________	________________________
Visual impairment	________	________	________	________________________
Wear glasses	________	________	________	________________________
Problems seeing on one side	________	________	________	________________________
See things that are not there	________	________	________	________________________
Brief periods of blindness	________	________	________	________________________
Need to squint/move closer	________	________	________	________________________
Hearing loss	________	________	________	________________________
Wear hearing aids	________	________	________	________________________
Ringing in ears	________	________	________	________________________
Hear strange sounds	________	________	________	________________________
Unaware of things one side of body	_______	________	________	________________________
Problems with taste	________	________	________	________________________
Problems with smell	________	________	________	________________________

Other sensory problems____

Intellectual Concerns

Problem Solving
Date of onset____________________________

Difficulty figuring out how to do things
Date of onset____________________________

Difficulty figuring out problems that most others can do
Date of onset____________________________

Difficulty planning ahead
Date of onset____________________________

Difficulty changing a plan or activity when necessary
Date of onset____________________________

Difficulty thinking as quickly as needed
Date of onset____________________________

Difficulty completing an activity in a reasonable time
Date of onset____________________________

Difficulty dong things in the right order (sequencing)
Date of onset____________________________

Language and Math Skills

Difficulty finding the right word
Date of onset______________________________

Slurred speech
Date of onset______________________________

Odd or unusual speech sounds
Date of onset______________________________

Difficulty expressing thoughts
Date of onset______________________________

Difficulty understanding what others say
Date of onset______________________________

Difficulty understanding what I read
Date of onset______________________________

Difficulty writing letters or words
Date of onset______________________________

Difficulty with Math
Date of onset______________________________

Other____

Nonverbal Skills

Difficulty telling right from left
Date of onset___________________________
Difficulty drawing or coping
Date of onset___________________________
Difficulty dressing (not due to motor problems)
Date of onset___________________________
Difficulty doing things I should automatically be able to do
Date of onset___________________________
Problems finding your way around similar places
Date of onset___________________________
Difficulty recognizing objects or people
Date of onset___________________________
Part of my body do not seem as if they belong to me
Date of onset___________________________
Decline in Muscle abilities
Date of onset___________________________
Not aware of the time
Date of onset___________________________
Slow reaction time
Date of onset___________________________

Memory

Forget where I leave things
Date of onset___________________________
Forget what I should be doing
Date of onset___________________________
Forget where I am or where I am going
Date of onset___________________________
Forget appointments
Date of onset___________________________
Forget events that happened long ago
Date of onset___________________________
More reliant on others to remind me of things
Date of onset___________________________
More reliant on notes to remember things
Date of onset___________________________
Forget the order or events
Date of onset___________________________
Forget facts but can remember how to do things
Date of onset___________________________
Forget faces of people I know (when not present)
Date of onset___________________________
Other__________________________________
Date of onset___________________________

Awareness and Concentration

Seeing things that no one else can see
Date of onset___________________________
Hearing things that no one else can hear
Date of onset___________________________
Agitation/feeling restless
Date of onset___________________________
Suicidal thoughts (plan____intent____attempt____)
Date of onset___________________________
Other____

Other____

Awareness and concentration…continued

Highly distractible
Date of onset___________________________
Lose my train of though easily
Date of onset___________________________
Difficulty doing more than one thing at a time
Date of onset___________________________
Becomes easily confused and disoriented
Date of onset___________________________
Aura (strange feelings)
Date of onset___________________________
Don't feel very alert or aware of things
Date of onset___________________________
Tasks require more effort or attention
Date of onset___________________________
Mood/Behavior/Personality
Date of onset___________________________
Sadness or Depression____Mild____Moderate___Severe
Date of onset___________________________
Anxiety or Nervousness
Date of onset___________________________
Stress _______Mild_______Moderate______Severe
Date of onset___________________________
Sleep problems______Falling asleep ______Staying asleep
Date of onset___________________________
Experience nightmares on a daily/weekly basis
Date of onset___________________________
Become angry more easily
Date of onset___________________________
Euphoria (feeling on top of the world)
Date of onset___________________________
Much more emotional (e.g. cry more easily)
Date of onset___________________________
Easily Frustrated
Date of onset___________________________
Doing things automatically (without awareness)
Date of onset___________________________
Less inhibited (do things I would not do before)
Date of onset___________________________
Difficulty being spontaneous
Date of onset___________________________
Change in energy (loss____increase____)
Date of onset___________________________
Change in appetite (loss____increase____)
Date of onset___________________________
Change in weight (loss____increase____)
Date of onset___________________________
Change in sexual interest (increase____decline____)
Date of onset___________________________
Lack of interest in pleasurable activities
Date of onset___________________________
Increase in irritability
Date of onset___________________________
Increase in aggression

Date of onset___________________________ Date of onset___________________________

Have others commented to you about changes in your thinking, behavior, personality, or mood? If yes, who and what have they said? ____Yes____ No

____

____

Are you experiencing any problems in the following aspects of your life? If so, explain_________________________________

Marital/Family____

____

Financial/Legal____

____

Housekeeping/Money Management____

____

Driving____

Overall my symptoms have develop _____Slowly _____Quickly My Symptoms Occur_____ Occasionally ____ Often

Over the past 6 months, my symptoms have ____ Improved ____ Stayed the same ____ Worsened

Is there anything you can do (or someone does) that gets the problem to stop or be less intense, less frequent, or shorter?______

____

What seems to make the problems worsen?____

____

In summery there is: ____Definitely something wrong with me ____Possibly something wrong with me _____Nothing wrong

What are your goals and aspirations for the future?____

____

You were born ____ on time _____ prematurely ____ late

Were there any problems associated with your birth? (E.g. oxygen deprivation, unusual birth position, etc,) or period afterward (e.g. need oxygen, convulsions, illness, etc.) ____ Yes ____ No

Describe____

Check all that applied t your mother while she was pregnant with you

- ____ Accident
- ____ Alcohol use
- ____ Cigarette smoking
- ____ Poor nutrition
- ____ Psychological
- ____ Medications (prescribed or OTC)
- ____ Drug use (THC, cocaine, LSD, etc.)
- ____ Illness (toxemia, diabetes, high blood pressure, etc,)
- ____ Other Problems: ____

Rate your developmental progress as it has been reported to you by checking one description for each area

Walking	____ Early	____ Average	____ Late
Language	____ Early	____ Average	____ Late
Toilet Training	____ Early	____ Average	____ Late
Overall Development	____ Early	____ Average	____ Late

As a child, did you have any of these conditions?

- ____ Attention Problems
- ____ Learning Disabilities
- ____ Clumsiness
- ____ Development Delay
- ____ Speech Problems
- ____ Hearing Problems
- ____ Hyperactivity
- ____ Frequent Ear infections
- ____ Muscle Weakness

Where were you raised?____

Who living in your home growing up?____

Did your parents divorce? If so how old were you when they separated? ___________________________

Did you have a positive relationship with your Mother? ________________________ Father?______________________

Have you ever been:

Sexually Abused: ____Yes ____ No Explain:________________________________

Physically Abuse ____Yes ____ No Explain:________________________________

Emotionally Abuse ____Yes ____No Explain:________________________________

Medical History: medical problems prior to the onset on current condition

Head Injury	Dates/Description______________________
Loss of consciousness	Dates/Description______________________
Motor vehicle accident	Dates/Description______________________
Major falls (sports accidents; industrial injuries)	Dates/Description______________________
Seizures	Dates/Description______________________
Stroke	Dates/Description______________________
Arteriosclerosis	Dates/Description______________________

Other brain infections or disease Dates/Description____
Diabetes Dates/Description____
Heart Disease Dates/Description____
Cancer Dates/Description____
Back or neck injury Dates/Description____
Serious Illness/disorder Dates/Description____
Depression Dates/Description____
Anxiety Dates/Description____
Problems with sleep Dates/Description____
Other psychiatric problems Dates/Description____
Bipolar disorder Dates/Description____
Schizophrenia Dates/Description____
Suicidal thoughts Dates/Description____
Poisoning Dates/Description____
Exposure toxins Dates/Description____
Other Dates/Description____

Medication List

Name Reason for taking Dosage Date Started

____
____
____
____
____
____
____
____
____

Are you currently in counseling or under psychiatric care? ____ Yes ____ No
Please list dates therapy initiated and names of professional(s) who treating you____
____
____
____

Have you ever been in counseling or under psychiatric care? ____ Yes ____ No
Please list dates of therapy and name(s) of professional(s) who treated you____
____
____
____

Please list all inpatient hospitalizations including the name of the hospital, date of the hospitalization, duration, and diagnosis.
____
____
____
____
____

Substance Use History

I started drinking at ____less than 10 ____ 10-15 ____ 16-19 ____ 20-21 _____ over 21
I drink alcohol ____ rarely or never ____1-2 day/week ____ 3-5day/week _____ daily
I used to drink alcohol ____ Yes ____ No ___________________ date stopped
My last drink was ____ less than 24 hours ago ____ over 48 hours ago ____ 24-48 hours ago
Preferred types of drinks _____________________________ Usual number of dinks at one time____________________
Check all that apply
____ I sometimes black out after drinking

____ I can drink more than most people my age and size before I get drunk
____ I sometimes get into trouble (fights , legal difficulties, work problems, conflicts with family accidents, etc after drinking (specify)____

Please check all the drugs you are now using or have used in the past

Amphetamines (Including diet pills)	____________using	____________used
Barbiturates	____________using	____________used
Cocaine or crack	____________using	____________used
Hallucinogenic (LSD, acid, STP, etc)	____________using	____________used
Marijuana	____________using	____________used
Opiates narcotics (heroin, morphine, etc)	____________using	____________used
PCP (Angel dust)	____________using	____________used
Others____________________________	____________using	____________used

Do you consider yourself dependent on the above drugs?	____Yes ____ No	Explain_____________________
Do you consider yourself dependent on any prescription drugs?	____Yes ____ No	Explain_____________________
I have gone through drug withdrawal	____Yes ____ No	Explain_____________________
I have used IV drugs	____Yes ____ No	Explain_____________________
I have been in drug treatment	____Yes ____ No	Explain_____________________
Has use of drugs affected your work performance	____Yes ____ No	Explain_____________________
Has use of drugs or alcohol affected your driving ability	____Yes ____ No	Explain_____________________
Do you smoke?	____Yes ____ No	Explain_____________________
Do you drink coffee?	____Yes ____ No	Explain_____________________

Family

The following questions deal with your biological mother, father, brothers, and sisters
Is your mother alive? ____Yes ____ No If deceased, what was the cause of death_________________________________
Mother's highest level of education________________________ Mother's education________________________________
Does your mother have a known learning disability? ____Yes ____ No Describe___________________________
Is your father alive? ____Yes ____ No If deceased, what was the cause of death_________________________________
Father's highest level of education________________________ Father's education________________________________
Does your father have a known learning disability? ____Yes ____ No Describe___________________________
How many brothers and sisters do you have? _________________________Ages?_____________________________
Are there any unusual problems (physical, academic, psychological) Associated with any of your brothers or sisters?
___Yes___No If yes, Describe____

Please check all problems that exist in close biological family members (parents, brothers, sisters, grandparents, aunts, uncles). Note who it is (was) and describe the problems where indicated.

Neurological Disease

Alzheimer's disease/senility	____Yes ____ No	Who_______________	Describe___________________________
Huntington's disease	____Yes ____ No	Who_______________	Describe___________________________
Multiple sclerosis	____Yes ____ No	Who_______________	Describe___________________________
Parkinson's disease	____Yes ____ No	Who_______________	Describe___________________________
Epilepsy or seizures	____Yes ____ No	Who_______________	Describe___________________________
Other neurologic disease	____Yes ____ No	Who_______________	Describe___________________________
Psychiatric Illness	____Yes ____ No	Who_______________	Describe___________________________
Depression	____Yes ____ No	Who_______________	Describe___________________________
Anxiety	____Yes ____ No	Who_______________	Describe___________________________
Bipolar Illness(manic-depression)	____Yes ____ No	Who_______________	Describe___________________________
Schizophrenia	____Yes ____ No	Who_______________	Describe___________________________
Suicide	____Yes ____ No	Who_______________	Describe___________________________
Other	____Yes ____ No	Who_______________	Describe___________________________

Other disorders

Mental Retardation	____Yes ____ No	Who_______________	Describe___________________________
Speech or language disorders	____Yes ____ No	Who_______________	Describe___________________________

Learning problems ____Yes ____ No Who_______________ Describe_____________________________
Attention problems ____Yes ____ No Who_______________ Describe_____________________________
Behavior problems ____Yes ____ No Who_______________ Describe_____________________________
Other major disease/disorder ____Yes ____ No Who_______________ Describe_____________________________

Social History

Current medical status ____never married ____ married ____living with partner ____separated____ divorced____ widowed
Years married to current partner______ Dates of previous marriage From______________ to___________________
Spouse Name_____________________ Dates of previous marriage From______________ to___________________
Spouse occupation____
Spouse health ____ Excellent ______ Good ____ Poor
Children (include stepchildren)
Name Age Gender Occupation
____
____
____
____
____
Who currently lives at home____
____
Do any family member have any significant health concerns/special needs? ___________________________
____
How would you describe your social network ____Stable ____Unstable ____Large ____Small
What social activities do you participate in? Group/Clubs? _______________________________________
____

Educational History

Elementary____
High School____
Trade School____
College/university____
If a high school diploma was not awarded; did you complete a GED? ________Yes ________No
Were any grades repeated? ____Yes ____No Reason: ____
Where there any special problems learning to read, write, or do math?
Where you ever in any special class or did you ever receive special service? ________Yes ________No
If yes, what grade_________________ What type of class_________________________________
How would you describe your usual performance as a student? _______A&B_______B&C________C&D________D&F
Provide any additional comments about your academic performance____________________________
____
Military
Did you ever serve in the military? ____Yes ____No If yes, what Branch____________________ Dates______________
Certifications/Duties____
____
Did you serve war time? ____If so, what arena____
Did you receive injuries or where you ever exposed to any dangerous or unusual substance during your service ____Yes____No
If yes, explain____
Do you have any continuing problems related to your military service? Describe___________________________
____
____

Occupational history

Are you currently…? __________employed __________unemployed __________retired ________disabled
Current job title____ Name of employer________________________
Current responsibilities____
Dates of employment____
Are you currently experiencing any problems at work? ____Yes ____No If yes, what_______________________________
Do you see your current work situation as stable? ______ Yes ____No If no, why________________________________
Approximate annual income Prior illness/injury_______________________ After illness/injury___________________
Previous Employers

Name	Date	Position	Reason for leaving

Legal History

Have you ever been arrested ____Yes ____No Describe: ____
____

Recreation

Briefly list the types of recreation (E.g. sports, games, TV, Hobbies, etc.) that you enjoy______________________________
____
____
Are you still able to enjoy these activities? ____

Recent tests

Check all tests that recently have been done and report any abnormal findings

Test	N/A	Normal	Abnormal Findings
Angiography	_____N/A	____Normal	Abnormal Findings____________
Blood work	_____N/A	____Normal	Abnormal Findings____________
MRI	_____N/A	____Normal	Abnormal Findings____________
CRT scan	_____N/A	____Normal	Abnormal Findings____________
PET Scan	_____N/A	____Normal	Abnormal Findings____________
SPECT	_____N/A	____Normal	Abnormal Findings____________
Skull x-ray	_____N/A	____Normal	Abnormal Findings____________
EEG	_____N/A	____Normal	Abnormal Findings____________
Neurological exam	_____N/A	____Normal	Abnormal Findings____________
Other	_____N/A	____Normal	Abnormal Findings____________

Identify the physician who is most familiar with your recent problems____
____
Date of last vision exam___________________________ Date of last hearing exam__________________________
Have you gad prior psychological or neuropsychological exam? ____Yes ____No Date________________________

If yes, complete the following

Psychologist____
Reason____
Findings____

Provide any additional information that you feel is relevant to this referral_________________________________
____
____
____
____