

Montgomery Office

10550 Montgomery Rd. Suite 33
 Cincinnati Ohio 45242

Direct: (513) 791-8080

Fax: (513) 791-8085

www.RiverhillsNeuro.com

ADULT NEUROPSYCHOLOGICAL INTAKE EXAM

Basic Demographics

NAME: _____ DATE: _____

Start time: _____ Stop time: _____ Hours: _____

REFERRAL SOURCE: _____

EXAM TYPE: Forensic Civil ___ Forensic Criminal ___ Worker's Comp ___ Disability ___
 Competency ___ Medical ___ Other _____

Tentative Dxs 1) _____ 2) _____ 3) _____

REASON FOR REFERRAL: _____

Age: _____ DOB: ___/___/___ Handedness: R ___ L ___ Mixed ___

Occupation: _____ Date last worked or disabled: ___/___/___

Onset of injury or illness: ___/___/___ First injury? N ___ Y ___ Date: ___/___/___

Describe: _____

Education: Number of years _____ College or Tech school: _____

Military history: N ___ Y ___ Legal History: N ___ Y ___

Race: Afro-American ___ Asian ___ American Indian ___ White ___ Hispanic ___ Other _____

Marital Status: S ___ M ___ Div ___ Sep ___ Wid ___ Other _____

Involved in Litigation: N ___ Y ___ Attorney name & phone number: _____

Notes: _____

INFORMED CONSENT OBTAINED? N ___ Y ___ If no, reason: _____

PATIENT'S CHIEF COMPLAINTS? _____

ACCIDENT/ILLNESS HISTORY: _____

CURRENT TREATMENT & TREATING PROFESSIONALS (who, what, when started, effectiveness)

CURRENT MEDICATIONS (what, dosage, frequency, when started, effectiveness)

PAST MEDICAL HISTORY (check where applicable)

Arthritis	_____	Falls	_____
Blackouts	_____	Hearing Deficits	_____
Blood Disorder	_____	Hypertension	_____
Brain Injury	_____	Hypoxia	_____
Cancer	_____	Lung Disease	_____
Cardiac Disease	_____	Motor Deficits	_____
CVA	_____	Renal Disease	_____
Diabetes	_____	Thyroid Disease	_____
Epilepsy	_____	Visual Deficits	_____
No previous illnesses	_____	Other (describe)	_____

PAST SURGERIES: _____

PRIOR DIAGNOSTIC TESTING (check where applicable)

MRI	_____	Date	_____	Results	_____
EEG	_____	Date	_____	Results	_____
Labs	_____	Date	_____	Results	_____

PAST PSYCH HISTORY

Psych outpatient tx: N___ Y___ # times:_____ Diagnosis:_____

Psych inpatient tx: N___ Y___ # times:_____ Diagnosis:_____

Family psych hx: N___ Y___ Describe: _____

ETOH/SUBSTANCE ABUSE HISTORY

Alcohol use: N___ Y___ Average # drinks per week _____ # of times DUI/DWI _____

Treatment: _____

Substance abuse: N___ Y___ Type, frequency, main choice, last used _____

Caffeine intake: N___ Y___ Type/amount _____

Smoking: N___ Y___ Amount _____ If quit, when? ____/____/____

Neurotoxin exposure: N___ Y___ Type & date: _____

PAIN ASSESSMENT

Headaches: N___ Y___ Location _____
Frequency: _____ Intensity (0 to 10) _____
What triggers? _____
What relieves? _____

Musculoskeletal: N___ Y___ Location _____
Frequency: _____ Intensity (0 to 10) _____
What triggers? _____
What relieves? _____

Total pain level now (0 to 10): _____

DEVELOPMENTAL PROBLEMS

Problems with Mom's pregnancy: N___ Y___ Describe: _____

Problems with Mom's delivery: N___ Y___ Describe: _____

Apgar Rating: _____

Developmental problems: N___ Y___ Describe: _____

Childhood history of (check where applicable)

Abuse	_____	Motor Problems	_____
Head Injury	_____	Seizures	_____
High Fevers	_____	Speech Problems	_____

FAMILY HISTORY

(record all pertinent history for nuclear family including age, health status, medications, psych status, work or educational status and cause of death, if applicable)

Father: _____

Mother: _____

Brother(s): _____

Sister(s): _____

Married: N___ Y___ How long: _____

Relationship: Supportive___ Neutral___ Stressful___ Destructive___

Divorced: N___ Y___ # of times:___ When___ Why _____
Custody problems _____ Comments: _____

Children: N___ Y___ Names & ages: _____
Hx behavioral problems: N___ Y___ Type: _____
Hx educational problems: N___ Y___ Describe: _____

LEGAL HISTORY

Arrests: N____ Y____ Reason: _____

Convictions: N____ Y____

Charges: _____

EDUCATIONAL HISTORY

Highest grade completed: _____ Graduated _____ or GED _____ Year _____

High school attended: _____ Disciplin _____

College or Tech school attended: _____ GPA: _____

Reasons for leaving school: _____

Best subject: _____ Grade: _____

Worst subject: _____ Grade: _____

Failed any grades: N____ Y____ Which: _____

Repeat any grades: N____ Y____ Which: _____

History of LD: N____ Y____ Describe: _____

History of ADD: N____ Y____ Treatment: _____

VOCATIONAL HISTORY

Employed: N____ Y____ Length of time in job: _____ Disability date: _____

Job duties: _____

Job problems: _____

Promotions/Problems with other jobs: _____

Past job history (what, where, when, reason for leaving)

MILITARY HISTORY

Military: N____ Y____ Service Branch: _____ Rank at discharge: _____

Job type: _____

Combat experience: N____ Y____ Describe: _____

Service connected disability: N____ Y____ Describe: _____

CURRENT FINANCIAL RESOURCES

Montgomery Office

10550 Montgomery Rd. Suite 33
Cincinnati Ohio 45242

Direct: (513) 791-8080
Fax: (513) 791-8085

www.RiverhillsNeuro.com

Consent For Psychological/Neuropsychological Evaluation

I understand that the purpose of this evaluation is to provide information about me for my physician or other health care provider who has requested the evaluation in order to assist in their diagnosis and treatment of me. The material from the interview(s) and psychological/neuropsychological testing will result in the generation of a report that will provide information related to diagnosis and treatment of me. The report generated by a neuropsychologist will be sent to my physician or other health care provider and the neuropsychologist may also discuss the results of the evaluation with them. If I desire, the neuropsychologist will also discuss the results with me and any others whom I so designate by signing a release of information allowing the neuropsychologist to do so. If this evaluation is being covered or partially covered by my insurance the office of Behavioral Medicine at Riverhills Neuroscience. may be required to provide the insurance company with a report as well.

Interview questions may touch on personal and private matters that could cause me emotional discomfort. I recognize that the neuropsychologist has no intention of causing any personal discomfort but that she is simply carrying out her professional task associated with this evaluation. Even though some of the subject under discussion may not appear at first glance to have a direct connection with this issue at hand, I will cooperate to the best of my ability. I understand that although I am expected to give honest and accurate answers, I am free to refuse to answer any question I choose or to terminate the evaluation whenever I wish.

The neuropsychologist is required to notify authorities if she knows of or suspects child abuse or abuse of the elderly, including but not limited to, physical and sexual abuse, or if she has reason to believe that I may harm others or myself. In addition, if I am involved in a legal action and/or claim mental health or neuropsychological issues related to the legal action, these records may be required to be released. Otherwise, communications between the neuropsychologist and me will be deemed confidential as stated under Ohio state law.

The terms of this evaluation had been reviewed, understood and agreed to by me.

Signature: _____

(Please Print Name)

Date: _____

Address: _____
(Street)

Guardian: _____

(City & State)

Phone: _____

Jeanne T. Schmerler, Psy.D.
Clinical Neuropsychologist

or

Megan O'Connor, PhD
Clinical Neuropsychologist

Riverhills Neuroscience

Montgomery Office

10550 Montgomery Rd. Suite 33
Cincinnati Ohio 45242

Direct: (513) 791-8080
Fax: (513) 791-8085

www.RiverhillsNeuro.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (Print Full Name) _____ (Date of Birth)

hereby authorize the release of from my medical record

from/to:

Name: **Riverhills Neuroscience**
Division of Behavioral Medicine
Megan M. O'Connor, Ph.D.
Jeanne T. Schmerler, Psy.D.

Address: **10550 Montgomery Road**
City, State, Zip: **Cincinnati, Ohio 45242**

to/from:

Name:

Address:
City, State, Zip:

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.

Purpose of disclosure: **continuity of care**

Information requested: **Neuropsychology report**

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken prior to the revocation. This authorization will expire 60 days after the date signed. The requestor may not redisclose my medical records to another party without further written consent.

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the treatment records to the purpose and extent stated above.

Date: _____ Signature: _____
(Patient or Legal Representative)

Date: _____ Witness: _____

A standardized fee has been established for copies of medical records requested for reason other than direct medical care. Please inquire about these fees before requesting copies.

Riverhills Neuroscience

RESPONSIBLE PARTY INFORMATION (if patient is a minor provide parent info)

Name _____ Relationship to patient _____

Soc Sec # _____ **Date of Birth** _____ **Phone #** _____

E-mail Address _____ **Cell Phone #** _____

Address _____ City _____ ST _____ Zip _____

Employer & Address _____ Work # _____

 Yes, I would like to receive information and updates via email.

PATIENT INFORMATION

Patient Name _____ Home Phone # _____

Address _____ City _____ ST _____ Zip _____

Soc Sec # _____ **DOB** _____ **Age** _____ **Sex** _____ **Marital Status** S M W D SEP

Occupation _____ **Cell Phone #** _____ **E-mail** _____

Patient' Employer _____ Work # _____

Work Address _____ City _____ ST _____ Zip _____

Spouse's name or Both Parents _____ Phone # _____

Emergency Contact _____ Relationship _____ Phone # _____

INJURY INFORMATION (if applicable)

Is this (circle) Work Related Auto Accident Other Accident

Date of injury/onset _____ How did injury happen _____

Area to be treated _____ Were X-rays/MRI taken _____ Where _____ When _____

Off work due to this injury YES NO If YES, first date missed _____

Insurance carrier _____ Address _____ City/ST/Zip _____

Phone # _____ Fax # _____ Contact Person _____

Claim # _____ Injury occurred in (circle) Kentucky Ohio Other

INSURANCE INFORMATION
Primary Insurance

Insurance Name _____

Address _____

Phone # _____

Policy No _____

Group No _____

Subscriber Name _____

Soc Sec # _____

Date of Birth _____

Employer _____

Secondary Insurance

Insurance Name _____

Address _____

Phone # _____

Policy No _____

Group No _____

Subscriber Name _____

Soc Sec # _____

Date of Birth _____

Employer _____

Allergies _____ History of Metal/Schrapnel _____ Smoker _____

Pharmacy _____ Phone # _____ Address _____

Family Phy (first/last) _____ Address _____ Phone # _____

Referring Phy (first/last) _____ Address _____ Phone # _____



HIPAA Privacy Practices Acknowledgement Form

I acknowledge that I have read the attached information, which includes the rights and responsibilities of both Riverhills Neuroscience and myself, as it pertains to confidentiality of medical information. I have received a copy of this privacy policy on this date.

Patient Health Information Disclosure

The HIPAA privacy rule was created to give individuals the right to restrict the release of their medical information and to designate to whom their information may be given. If so desired, the patient may request confidential communications of Riverhills (protected health information) and/or designate where this information should be sent, such as home or office.

The physicians and staff of Riverhills Neuroscience may contact me in the following manner:
(Please check all that apply)

- Home Telephone: _____
 - Yes. You may leave information on my home voicemail.
- Cellular Telephone: _____
 - Yes. You may leave information on my cellular voicemail.
- Work Telephone: _____
 - Yes. You may leave information on my work voicemail.
- Written communication.
- Mail to my home address.
- Fax to: _____
- Your Private Health Information (PHI) may be released to the following:

Print Name: _____

Date of Birth: _____

Patient Signature: _____

Date: _____

This disclosure authorization remains in effect until revoked by the patient.

Riverhills Neuroscience