CorePsych

Adult Intake Information

5029 Corporate Woods Dr., Ste. 250, Virginia Beach VA 23462
757.671.1776 - FX: 757.473.3768

Please Return and Make Appointments Here: http://www.corepsych.com/appointments

PATIENT **INFORMATION**

Patient's Name: _____ SS# ____-____-____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address: _____

Home Phone: (_____)_____ Occupation: _____ ☐ Student

Employer (School, if student): _____ Work/School Phone: (_____)_____

Employer/School Address: _____

E-mail Address [clearly]: _____Permission to add Email to Database for CP updates___

Driver's License Number: _____ Fax Phone: (_____)_____

RESPONSIBLE PARTY and/or SPOUSE'S INFORMATION

Responsible Party: _____ SS# ____-____-____ Date of Birth: _____

Home Address: _____

Home Phone: (_____)_____ Occupation: _____

Employer: _____ Work Phone: (_____)_____

Employer Address: _____ Driver's License No.: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name: _____ SS# ____-____-____ Date of Birth: _____

Spouse's Employer: _____ Address: _____

REFERRAL SOURCE _____Address _____
Phone #_____ Fax # _____ Do we have your permission to release information to the referring professional? Yes __ No __ Do we have permission to leave a message on your phone or answering machine should you call? Yes__ No__

INSURANCE BILLING: We do not bill insurance. We will provide patients with receipts that may be submitted to insurance carriers for reimbursement. Patients/Responsible Parties are responsible for all charges.

PAYMENT POLICY: Payments may be made by cash or personal check (in office) or credit card (MasterCard or Visa). Patients are expected to maintain a zero balance. Accounts need to stay current in order to maintain ongoing treatment.

FEES CHARGED: The fees charged by doctors/therapists at CorePsych are based on the amount of time scheduled for dealing with patient issues. The minimum amount of time scheduled/charged by our physicians is for a half session (30 minutes in length). In addition, patients are charged for time taken to write reports or correspondence on patient's behalf.

APPOINTMENT CANCELLATION POLICY: CorePsych require that cancellations for scheduled appointments be received 24 hours in advance during regular office hours (Monday through Friday 8:30am to 5:00pm).

Failed or cancelled appointments that do not follow this policy will be charged.

***I have read and understand the above stated policies of* COREPSYCH.**

***Signature of Responsible Party* (required):** _____

CorePsych Adult Intake Questionnaire

In order for us to be able to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your medical chart it is ok to refrain from putting it in this information. Thank you!

Who are you currently living with?

_____

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME?
What do you want this clinic to do for your child, yourself or your family?

_____

_____

_____

PRIOR PSYCHIATRIC MEDICATIONS (Please list all medications taken alone and all medications taken in combination; including dosages, effectiveness and any side-effects.) See the meds list, last pg.

Date Taken	**Medication** ***Individual or Combinations*** ***Dosage(s) and time(s) taken per day***	**Effectiveness**	**Side-Effects/Problems**
Ex: 3/2000- 12/2005	**Example** • *Ritalin 5 mg BID* • *Prozac 10mg QAM*	**Example** *Improved concentration in morning, still moody*	**Example** *Felt very unfocused in evening; hyperactive in evenings; dry motuh*

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY
(Please include contact with other professionals and types of treatment, etc; please use chart above for medications.)

_____
_____
_____
_____

MEDICAL HISTORY
Current medical problems/medications:_____
_____
_____
Current supplemets/vitamins/herbs:_____
_____
Past medical problems/medications: _____
_____
Other doctors/clinics seen regularly: _____
_____
Any history of head trauma? (describe/age): _____
Ever any seizures or seizure like activity? _____
Prior hospitalizations (place, cause, date, outcome): _____
Prior abnormal lab tests, X-rays, EEG, etc: _____
Allergies/drug intolerances (describe): _____
Present Height _____ *Present Weight* _____

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children)_____
_____

Prenatal and birth events: Your parents attitude toward their pregnancy with you
_____
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc_____
Any birth problems, trauma, forceps or complications?:
_____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)
_____
_____

School History: Last grade completed _____ Last school attended _____
Average grades received _____ Specific learning disabilities _____
Learning strengths _____
Any behavior problems in school? _____
What have teachers said about you_____
Please bring school report cards and any state, national or special testing that has been performed.

Employment History: (summarize jobs you've had, list most favorite and least favorite)
_____
_____
Any work-related problems?
_____
What would your employers or supervisors say about you?
_____

Military History?
_____

Legal Problems? _____

Sexual history: (answer only as much as you feel comfortable)
Any history of sexually transmitted disease? _____ History of abortion? _____
History of sexual abuse, molestation or rape? _____
Current sexual problems?_____

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP.

_____
_____
_____
_____

Ever experience withdrawal symptoms from alcohol or drugs?

_____

Has anyone told you they thought you had a problem with drugs or alcohol?

_____

Have you ever felt guilty about your drug or alcohol use?

_____

Have you ever felt annoyed when someone talked to you about your drug or alcohol use?

_____

Have you ever used drugs or alcohol first thing in the morning?_____

Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate)

_____

Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew)

_____

FAMILY HISTORY

Family Structure (who lives in your current household, please give relationship to each):

_____
_____

Current Marital or Relationship Satisfaction_____

_____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)_____

_____
_____

History of Past Marriages _____

Natural Mother's History: age_____ outside work _____
School: highest grade completed _____
Learning problems _____ Behavior problems _____
Marriages _____

Medical Problems _____
Childhood atmosphere (family position, abuse, illnesses, etc)_____
_____
Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____
_____
Mother's alcohol/drug use history _____
Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)_____
_____

Natural Father's History: age_____ outside work _____
School: highest grade completed _____
Learning problems _____ Behavior problems _____
Marriages _____
Medical Problems _____
Childhood atmosphere (family position, abuse, illnesses, etc)_____
_____
Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____
_____
Father's alcohol/drug use history _____
Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)_____
_____

Siblings (names, ages, problems, strengths, relationship to patient) _____
_____
_____
_____

Children (names, ages, problems, strengths) _____
_____
_____

Cultural/Ethnic Background _____
_____

Describe your relationships with friends _____
_____

Describe yourself _____
_____

Describe your strengths _____
_____

Adult General Symptom Checklist

Return to: *CorePsych*: 5029 Corporate Woods Dr., Ste 250, Va Beach, VA 23462, Fax 757.473.3768
Or Create PDF and Drop at Documents Here: http://www.corepsych.com/appointments

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List other person_____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Other Self

____ ___ 1. depressed or sad mood
____ ___ 2. decreased interest in things that are usually fun, including sex
____ ___ 3. significant weight gain or loss, or marked appetite changes, increased or decreased
____ ___ 4. recurrent thoughts of death or suicide
____ ___ 5. sleep changes, lack of sleep or marked increase in sleep
____ ___ 6. physically agitated or "slowed down"
____ ___ 7. low energy or feelings of tiredness
____ ___ 8. feelings of worthlessness, helplessness, hopelessness or guilt
____ ___ 9. decreased concentration or memory
____ ___ 10. periods of an elevated, high or irritable mood
____ ___ 11. periods of a very high self esteem or grandiose thinking
____ ___ 12. periods of decreased need for sleep without feeling tired
____ ___ 13. more talkative than usual or pressure to keep talking
____ ___ 14. racing thoughts or frequent jumping from one subject to another
____ ___ 15. easily distracted by irrelevant things
____ ___ 16. marked increase in activity level
____ ___ 17. excessive involvement in pleasurable activities which have the potential for painful consequences: (spending money, sexual indiscretions, gambling, foolish business ventures)
____ ___ 18. panic attacks, which are periods of intense, unexpected fear or emotional discomfort (list number per month ____)
____ ___ 19. periods of trouble breathing of feeling smothered
____ ___ 20. periods of feeling dizzy, faint or unsteady on your feet
____ ___ 21. periods of heart pounding or rapid heart rate
____ ___ 22. periods of trembling or shaking
____ ___ 23. periods of sweating
____ ___ 24. periods of choking
____ ___ 25. periods of nausea or abdominal upset
____ ___ 26. feelings of a situation "not being real"
____ ___ 27. numbness or tingling sensations
____ ___ 28. hot or cold flashes
____ ___ 29. periods of chest pain or discomfort
____ ___ 30. fear of dying
____ ___ 31. fear of going crazy or doing something uncontrolled
____ ___ 32. avoiding everyday places for fear of having a panic attack or needing to go with other people in order to feel comfortable
____ ___ 33. excessive fear of being judged by others which causes you to avoid or get anxious in situations
____ ___ 34. persistent, excessive phobia (heights, closed spaces, specific animals, etc.) please list _____
____ ___ 35. recurrent bothersome thoughts, ideas or images which you try to ignore
____ ___ 36. trouble getting "stuck" on certain thoughts, or having the same thought over and over
____ ___ 37. excessive or senseless worrying
____ ___ 38. others complain that you worry too much or get "stuck" on the same thoughts
____ ___ 39. compulsive behaviors that you must do or you feel very anxious, such as excessive hand washing, checking locks, or counting or spelling

____ ___ 40. needing to have things done a certain way or you become very upset

____ ___ 41. others complain that you do the same thing over and over to an excessive degree (such as cleaning or checking)
____ ___ 42. recurrent and upsetting thoughts of a past traumatic event (molest, accident, fire, etc.) please list
____ ___ 43. recurrent distressing dreams of a past upsetting event
____ ___ 44. a sense of reliving a past upsetting event
____ ___ 45. a sense of panic or fear to events that resemble an upsetting past event
____ ___ 46. you spend effort avoiding thoughts or feelings associated with a past trauma
____ ___ 47. persistent avoidance of activities/situations which cause remembrance of upsetting event
____ ___ 48. inability to recall an important aspect of a past upsetting event
____ ___ 49. marked decreased interest in important activities
____ ___ 50. feeling detached or distant from others
____ ___ 51. feeling numb or restricted in your feelings
____ ___ 52. feeling that your future is shortened
____ ___ 53. quick startle
____ ___ 54. feels like you're always watching for bad things to happen
____ ___ 55. marked physical response to events that remind you of a past upsetting event, i.e., sweating when getting in a car if you had been in a car accident
____ ___ 56. marked irritability or anger outbursts
____ ___ 57. unrealistic or excessive worry in at least a couple areas of your life
____ ___ 58. trembling, twitching or feeling shaky
____ ___ 59. muscle tension, aches or soreness
____ ___ 60. feelings of restlessness
____ ___ 61. easily fatigued
____ ___ 62. shortness of breath or feeling smothered
____ ___ 63. heart pounding or racing
____ ___ 64. sweating or cold clammy hands
____ ___ 65. dry mouth
____ ___ 66. dizziness or lightheadedness
____ ___ 67. nausea, diarrhea or other abdominal distress
____ ___ 68. hot or cold flashes
____ ___ 69. frequent urination
____ ___ 70. trouble swallowing or "lump in throat"
____ ___ 71. feeling keyed up or on edge
____ ___ 72. quick startle response or feeling jumpy
____ ___ 73. difficult concentrating or "mind going blank"
____ ___ 74. trouble falling or staying asleep
____ ___ 75. irritability
____ ___ 76. trouble sustaining attention or being easily distracted
____ ___ 77. difficulty completing projects
____ ___ 78. feeling overwhelmed of the tasks of everyday living
____ ___ 79. trouble maintaining an organized work or living area
____ ___ 80. inconsistent work performance
____ ___ 81. lacks attention to detail
____ ___ 82. makes decisions impulsively
____ ___ 83. difficulty delaying what you want, having to have your needs met immediately
____ ___ 84. restless, fidgety
____ ___ 85. make comments to others without considering their impact
____ ___ 86. impatient, easily frustrated
____ ___ 87. frequent traffic violations or near accidents
____ ___ 88. refusal to maintain body weight above a level most people consider healthy
____ ___ 89. intense fear of gaining weight or becoming fat even though underweight
____ ___ 90. feelings of being fat, even though you're underweight
____ ___ 91. recurrent episodes of binge eating large amounts of food
____ ___ 92. a feeling of lack of control over eating behavior
____ ___ 93. engage in regular activities to purge binges, such as self induced vomiting, laxatives, diuretics, strict dieting or strenuous exercise
____ ___ 94. persistent over concern with body shape and weight

____ ___ 95a. involuntary physical movements or motor tics (such as eye blinking, shoulder shrugging, head jerking or picking). How long have motor tics been present?_____ How often?_____ describe_____

____ ___ 95b. involuntary vocal sounds or verbal tics (such as coughing, puffing, blowing, whistling, swearing). How long have verbal tics been present?_____ How often?_____ describe_____

____ ___ 96. delusional or bizarre thoughts (thoughts you know others would think are false)

____ ___ 97. seeing objects, shadows or movements that are not real

____ ___ 98. hearing voices or sounds that are not real

____ ___ 99. periods of time where your thoughts or speech were disjointed or didn't make sense to you or others

____ ___ 100. social isolation or withdrawal

____ ___ 101. severely impaired ability to function at home or at work

____ ___ 102. peculiar behaviors

____ ___ 103. lack of personal hygiene or grooming

____ ___ 104. inappropriate mood for the situation (i.e., laughing at sad events)

____ ___ 105. marked lack of initiative

____ ___ 106. frequent feelings that someone or something is out to hurt you or discredit you

____ ___ 107. do you snore loudly (or do others complain about your snoring)

____ ___ 108. have others said you stop breathing when you sleep

____ ___ 109. do you feel fatigued or tired during the day

____ ___ 110. do you often feel cold when others feel fine or they are warm

____ ___ 111. do you often feel warm when others feel fine or they are cold

____ ___ 112. do you have problems with brittle or dry hair

____ ___ 113. do you have problems with dry skin

____ ___ 114. do you have problems with sweating

____ ___ 115. do you have problems with chronic anxiety or tension

____ ___ 116. impairment in communication as manifested by at least one of the following:

- delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
- in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
- repetitive use of language or odd language
- lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

____ ___ 117. impairment in social interaction, with at least two of the following:

- marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
- failure to develop peer relationships appropriate to developmental level
- lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
- lack of social or emotional reciprocity

____ ___ 118. repetitive patterns of behavior, interests, and activities, as manifested by at least one of following:

- preoccupation with an area of that is abnormal either in intensity or focus
- rigid adherence to specific, nonfunctional routines or rituals
- repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- persistent preoccupation with parts of objects

Amen Brain System Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List other _____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Other	Self		
____	___	1.	Fails to give close attention to details or makes careless mistakes
____	___	2.	Trouble sustaining attention in routine situations (i.e. homework, chores, paperwork)
____	___	3.	Trouble listening
____	___	4.	Fails to finish things
____	___	5.	Poor organization for time or space (such as backpack, room, desk, paperwork)
____	___	6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
____	___	7.	Loses things
____	___	8.	Easily distracted
____	___	9.	Forgetful
____	___	10.	Poor planning skills
____	___	11.	Lack clear goals or forward thinking
____	___	12.	Difficulty expressing feelings
____	___	13.	Difficulty expressing empathy for others
____	___	14.	Excessive daydreaming
____	___	15.	Feeling bored
____	___	16.	Feeling apathetic or unmotivated
____	___	17.	Feeling tired, sluggish or slow moving
____	___	18.	Feeling spacey or “in a fog”
____	___	19.	Fidgety, restless or trouble sitting still
____	___	20.	Difficulty remaining seated in situations where remaining seated is expected
____	___	21.	Runs about or climbs excessively in situations in which it is inappropriate
____	___	22.	Difficulty playing quietly
____	___	23.	"On the go" or acts as if "driven by a motor"
____	___	24.	Talks excessively
____	___	25.	Blurts out answers before questions have been completed
____	___	26.	Difficulty waiting turn
____	___	27.	Interrupts or intrudes on others (e.g., butts into conversations or games)
____	___	28.	Impulsive (saying or doing things without thinking first)
____	___	29.	Excessive or senseless worrying
____	___	30.	Upset when things do not go your way
____	___	31.	Upset when things are out of place
____	___	32.	Tendency to be oppositional or argumentative
____	___	33.	Tendency to have repetitive negative thoughts
____	___	34.	Tendency toward compulsive behaviors
____	___	35.	Intense dislike for change
____	___	36.	Tendency to hold grudges
____	___	37.	Trouble shifting attention from subject to subject
____	___	38.	Trouble shifting behavior from task to task
____	___	39.	Difficulties seeing options in situations
____	___	40.	Tendency to hold on to own opinion and not listen to others
____	___	41.	Tendency to get locked into a course of action, whether or not it is good
____	___	42.	Needing to have things done a certain way or you become very upset
____	___	43.	Others complain that you worry too much
____	___	44.	Tend to say no without first thinking about question
____	___	45.	Tendency to predict fear
____	___	46.	Frequent feelings of sadness
____	___	47.	Moodiness
____	___	48.	Negativity
____	___	49.	Low energy

____ ___50. Irritability
____ ___51. Decreased interest in others
____ ___52. Decreased interest in things that are usually fun or pleasurable
____ ___53. Feelings of hopelessness about the future
____ ___54. Feelings of helplessness or powerlessness
____ ___55. Feeling dissatisfied or bored
____ ___56. Excessive guilt
____ ___57. Suicidal feelings
____ ___58. Crying spells
____ ___59. Lowered interest in things usually considered fun
____ ___60. Sleep changes (too much or too little)
____ ___61. Appetite changes (too much or too little)
____ ___62. Chronic low self-esteem
____ ___63. Negative sensitivity to smells/odors
____ ___64. Frequent feelings of nervousness or anxiety
____ ___65. Panic attacks
____ ___66. Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)
____ ___67. Periods of heart pounding, rapid heart rate or chest pain
____ ___68. Periods of trouble breathing or feeling smothered
____ ___69. Periods of feeling dizzy, faint or unsteady on your feet
____ ___70. Periods of nausea or abdominal upset
____ ___71. Periods of sweating, hot or cold flashes
____ ___72. Tendency to predict the worst
____ ___73. Fear of dying or doing something crazy
____ ___74. Avoid places for fear of having an anxiety attack
____ ___75. Conflict avoidance
____ ___76. Excessive fear of being judged or scrutinized by others
____ ___77. Persistent phobias
____ ___78. Low motivation
____ ___79. Excessive motivation
____ ___80. Tics (motor or vocal)
____ ___81. Poor handwriting
____ ___82. Quick startle
____ ___83. Tendency to freeze in anxiety provoking situations
____ ___84. Lacks confidence in their abilities
____ ___85. Seems shy or timid
____ ___86. Easily embarrassed
____ ___87. Sensitive to criticism
____ ___88. Bites fingernails or picks skin
____ ___89. Short fuse or periods of extreme irritability
____ ___90. Periods of rage with little provocation
____ ___91. Often misinterprets comments as negative when they are not
____ ___92. Irritability tends to build, then explodes, then recedes, often tired after a rage
____ ___93. Periods of spaciness or confusion
____ ___94. Periods of panic and/or fear for no specific reason
____ ___95. Visual or auditory changes, such as seeing shadows or hearing muffled sounds
____ ___96. Frequent periods of deja vu (feelings of being somewhere you have never been)
____ ___97. Sensitivity or mild paranoia
____ ___98. Headaches or abdominal pain of uncertain origin
____ ___99. History of a head injury or family history of violence or explosiveness
____ ___100. Dark thoughts, may involve suicidal or homicidal thoughts
____ ___101. Periods of forgetfulness or memory problems

Learning Disability
Screening Questionnaire

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person (such as a spouse, partner or parent) rate you as well. List other person_____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Other Self

Reading

____ ___ 1. I am a poor reader.
____ ___ 2. I do not like reading.
____ ___ 3. I make mistakes when reading like skipping words or lines.
____ ___ 4. I read the same line twice.
____ ___ 5. I have problems remembering what I read even though I have read all the words.
____ ___ 6. I reverse letters when I read (such as b/d, p/q).
____ ___ 7. I switch letters in words when reading (such as god and dog).
____ ___ 8. My eyes hurt or water when I read.
____ ___ 9. Words tend to blur when I read.
____ ___ 10. Words tend to move around the page when I read.
____ ___ 11. When reading I have difficulty understanding the main idea or identifying important details.

Writing

____ ___ 12. I have "messy " handwriting.
____ ___ 13. My work tends to be messy.
____ ___ 14. I prefer print rather than writing in cursive.
____ ___ 15. My letters run into each other or there is no space between words.
____ ___ 16. I have trouble staying within lines.
____ ___ 17. I have problems with grammar or punctuation.
____ ___ 18. I am a poor speller.
____ ___ 19. I have trouble copying off the board or from a page in a book.
____ ___ 20. I have trouble getting thoughts from my brain to the paper.
____ ___ 21. I can tell a story but cannot write it.

Body Awareness/ Spatial Relationships

____ ___ 22. I have trouble with knowing my left from my right.
____ ___ 23. I have trouble keeping things within columns or coloring within lines.
____ ___ 24. I tend to be clumsy, uncoordinated.
____ ___ 25. I have difficulty with eye hand coordination.
____ ___ 26. I have difficulty with concepts such as up, down, over or under.
____ ___ 27. I tend to bump into things when walking.

Oral Expressive language

____ ___ 28. I have difficulty expressing myself in words.
____ ___ 29. I have trouble finding the right word to say in conversations.
____ ___ 30. I have trouble talking around a subject or getting to the point in conversations.

Receptive language

____ ___ 31. I have trouble keeping up or understanding what is being said in conversations.
____ ___ 32. I tend to misunderstand people and give the wrong answers in conversations.
____ ___ 33. I have trouble understanding directions people tell me.
____ ___ 34. I have trouble telling the direction sound is coming from.
____ ___ 35. I have trouble filtering out background noises.

Math

____ ___ 36. I am poor at basic math skills for my age (adding, subtracting, multiplying and dividing)
____ ___ 37. I makes "careless mistakes" in math.
____ ___ 38. I tend to switch numbers around.
____ ___ 39. I have difficulty with word problems.

Sequencing

____ ___ 40. I have trouble getting everything in the right order when I speak.
____ ___ 41. I have trouble telling time.
____ ___ 42. I have trouble using the alphabet in order.
____ ___ 43. I have trouble saying the months of the year in order.

Abstraction

____ ___ 44. I have trouble understanding jokes people tell me.
____ ___ 45. I tend to take things too literally.

Organization

____ ___ 46. My notebook/paperwork is messy or disorganized.
____ ___ 47. My room is messy.
____ ___ 48. I tend to shove everything into my backpack, desk or closet.
____ ___ 49. I have multiple piles around my room.
____ ___ 50. I have trouble planning my time.
____ ___ 51. I am frequently late or in a hurry.
____ ___ 52. I often do not write down assignments or tasks and end up forgetting what to do.

Memory

____ ___ 53. I have trouble with my memory.
____ ___ 54. I remember things from long ago but not recent events.
____ ___ 55. It is hard for me to memorize things for school or work.
____ ___ 56. I know something one day but do not remember it to the next.
____ ___ 57. I forget what I am going to say right in the middle of saying it.
____ ___ 58. I have trouble following directions that have more than one or two steps.

Social Skills

____ ___ 59. I have few or no friends.
____ ___ 60. I have trouble reading body language or facial expressions of others.
____ ___ 61. My feelings are often or easily hurt.
____ ___ 62. I tend to get into trouble with friends, teachers, parents or bosses.
____ ___ 63. I feel uncomfortable around people I do not know well.
____ ___ 64. I am teased by others.
____ ___ 65. Friends do not call and ask me to do things with them.
____ ___ 66. I do not get together with others outside of school or work.

Scotopic Sensitivity

____ ___ 67. I am light sensitive. Bothered by glare, sunlight, headlights or streetlights.
____ ___ 68. I become tired, experience headaches, mood changes, feel restless or an inability to stay focused with bright or fluorescent lights.
____ ___ 69. I have trouble reading words that are on white, glossy paper.
____ ___ 70. When reading words or letters shift, shake, blur, move, run together, disappear or become difficult to perceive.
____ ___ 71. I feel tense, tired, sleepy, or even get headaches with reading
____ ___ 72. I have problems judging distance and have difficulty with such things as escalators, stairs, ball sports, or driving..

Sensory Integration Issues

____ ___ 73. I seem to be more sensitive to the environment than others.
____ ___ 74. I am more sensitive to noise than others.
____ ___ 75. I am particularly sensitive to touch or very sensitive to certain clothing or tags on the clothing.

____ ___ 76. I have unusual sensitivity to certain smells.
____ ___ 77. I have unusual sensitivity to light.
____ ___ 78. I am sensitive to movement or crave spinning activities?
____ ___ 79. I tend to be clumsy or accident-prone.

Medical Review of Systems

Please place a check mark in the boxes that apply. Explain any problem areas.

General

- ❑ Being overweight
- ❑ Recent weight gain or weight loss
- ❑ Poor appetite
- ❑ Increased appetite
- ❑ Abnormal sensitivity to cold
- ❑ Cold sweats during the day
- ❑ Tired or worn out
- ❑ Hot or cold spells
- ❑ Abnormal sensitivity to heat
- ❑ Excessive sleeping
- ❑ Difficulty sleeping
- ❑ Lowered resistance to infection
- ❑ Flu-like or vague sick feeling
- ❑ Sweating excessively at night
- ❑ Urinating excessively
- ❑ Excessive daytime sweating
- ❑ Excessive thirst
- ❑ Other_____

Neurological

- ❑ Pacing due to muscle restlessness
- ❑ Forgotten periods of time
- ❑ Dizziness
- ❑ Drowsiness
- ❑ Muscle spasms or tremors
- ❑ Impaired ability to remember
- ❑ "Tics"
- ❑ Numbness
- ❑ Convulsions / fits
- ❑ Slurred speech
- ❑ Speech problem (other)
- ❑ Weakness in muscles
- ❑ Other_____

Respiratory

- ❑ Asthma, wheezing
- ❑ Cough
- ❑ Coughing up blood or sputum
- ❑ Shortness of breath
- ❑ Rapid breathing
- ❑ Repeated nose or chest colds
- ❑ Other_____

Chest and Cardiovascular

- ❑ Ankle swelling
- ❑ Rapid / irregular pulse
- ❑ Breast tenderness
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Other_____

Head, Eye, Ear, Nose, & Throat

- ❑ Facial pain
- ❑ Headache
- ❑ Head injury
- ❑ Neck pain or stiffness
- ❑ Frequent sore throat
- ❑ Blurred vision
- ❑ Double vision
- ❑ Overly sensitive to light
- ❑ See spots or shadows
- ❑ Hearing loss in both ears
- ❑ Ear ringing
- ❑ Disturbances in smell
- ❑ Runny nose
- ❑ Dry mouth
- ❑ Sore tongue
- ❑ Other_____

Gastrointestinal and Hepatic

- ❑ Trouble swallowing
- ❑ Nausea or vomiting (throwing up)
- ❑ Abdominal (stomach / belly) pain
- ❑ Anal itching
- ❑ Painful bowel movements
- ❑ Infrequent bowel movements
- ❑ Liquid bowel movements
- ❑ Loss of bowel control
- ❑ Frequent belching or gas
- ❑ Vomiting blood
- ❑ Rectal bleeding (red or black blood)
- ❑ Jaundice (yellowing of skin)
- ❑ Other_____

Musculoskeletal

- ❑ Back pain or stiffness
- ❑ Bone pain
- ❑ Joint pain or stiffness
- ❑ Leg pain
- ❑ Muscle cramps or pain
- ❑ Other_____

Skin, Hair

- ❑ Dry hair or skin
- ❑ Itchy skin or scalp
- ❑ Easy bruising
- ❑ Hair loss
- ❑ Increased perspiration
- ❑ Sun sensitivity
- ❑ Other_____

Genitourinary

- ❑ Itchy privates or genitals
- ❑ Painful urination
- ❑ Excessive urination
- ❑ Difficulty in starting urine
- ❑ Accidental wetting of self
- ❑ Pus or blood in urine
- ❑ Decreased sexual desire
- ❑ Other_____

Females

- ❑ See the female questions below in more detail

Other_____

Males

- ❑ Impotence (weak male erection)
- ❑ Inability to ejaculate or orgasm
- ❑ Scrotal pain
- ❑ Abnormal penis discharge
- ❑ Decreased libido, sex drive

Other_____

Explanation

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Female Hormone Questionnaire

PATIENT IDENTIFICATION
Name:_____ Age: _____
First Day Last Menstrual Period FDLMP_____[if active]
Number of Pregnancies: _____ Current Hormone Meds _____
Birth Control Practice _____
Number of Births: _____ Number of Miscarriages:_____
GYN Procedures, Surgery: _____
_____

1. Age Period Started_____ Age Period Ended _____
2. Periods at Onset: Regular_____ Irregular _____
   Other _____
3. Periods Now: Regular _____ Irregular _____
   Other _____
4. Duration of Period: _____ Days
5. Times of No Period: _____
6. History of Failure to Conceive: Yes _____ No _____
7. Cramps Intensity: Average_____ Moderate _____ Severe_____
8. Blood Flow: Average _____ Moderate _____ Severe_____
9. Start Birth Control_____ Why_____
10. Breasts Tender During Period: Yes _____ No _____ Breast Pain Ever? _____
11. Feel the Egg "Come Down" Mid Period: Yes _____ No _____
12. PMS: Yes _____ No____ If yes, how many days average? _____
13. Pre Menstrual Depression PMDD: Yes _____ No _____
14. Post Partum Depression: Yes _____ No _____ Number _____ Treated with Meds:_____
15. Fibrocystic Breast Disease: Yes _____ No _____
16. Fibroids: Yes _____ No _____
17. Cancer: Breast __ Ovarian __Uterine __ Cervical ___Dates _____
18. Acne Adolescent or Adult: Face _____ Chest _____ Back_____ Other _____
19. Excess Hair __ Face _____ Back _____ Chest _____ Other_____
20. Polycystic Ovaries: Yes _____ No _____
21. Other Hormonal Conditions: Thyroid Problems _____ Adrenal Problems _____ Diabetes _____ Last Checked for Thyroid _____ Last Checked Glucose _____
22. Hot Flashes: _____ Sweats ____ Weight Gain ____ Sleep Issues _____
23. "Female Problems/STD:"_____

Brain SPECT Informed Consent Form

What is Brain SPECT Imaging? Brain SPECT imaging is a nuclear medicine procedure that uses very small doses of a radioactive substance by intravenous injection that will give you and your doctor information on the cerebral blood flow and activity patterns of your brain.

What is the purpose of the Brain SPECT Imaging Procedure? This clinic and other clinics around the country have correlated certain mental and behavioral states with certain SPECT patterns. The information from the SPECT studies will help you and your doctor understand your specific brain patterns, which may further help in your evaluation and treatment.

Will the SPECT study give me an accurate diagnosis? No. A SPECT study by itself will not give a diagnosis. SPECT imaging helps the clinician understand more about the specific function of your brain. Each person's brain is unique which may lead to unique responses to medicine or therapy. Diagnoses about specific conditions are made through a combination of clinical history, personal interview, information from families, checklists, SPECT studies and other neuropsychological tests. No study by itself is a "doctor in a box" that can give accurate diagnoses on individual patients.

Why are SPECT studies ordered? Some of the common reasons include:

1. Evaluating suspected seizure activity
2. Evaluating suspected cerebral vascular disease
3. Evaluating cognitive decline and suspected dementia or other memory problems
4. Evaluating the effects of mild, moderate and severe head trauma
5. Evaluating the presence of a suspected underlying organic brain condition, such as seizure activity, that contributes to behavioral or emotional disturbance
6. Evaluating aggressive or suicidal behavior
7. Evaluating the extent of brain impairment caused by drug or alcohol abuse or other toxic exposure
8. Subtyping the physiology underlying mood disorders, anxiety disorders, or attention deficit disorders
9. Evaluating atypical, unresponsive or mixed psychiatric condition
10. Following up to evaluate the physiological effects of treatment
11. General brain health check up

Do I need to be off medication before the study? This question must be answered individually between you and your doctor. In general, it is better to be off medications until they are out of your system, but this is not always practical or advisable. If the study is done while on medication, make sure to note it on the appropriate forms. In general, we recommend patients try to be off stimulants at least four days before the first scan and remain off of them until after the second scan is done (if you are having two scans). Medications such as Prozac (which lasts in the body 4-6 weeks) are generally not stopped because of practicality. Check with your specific doctor for recommendations.

What should I do the day of the scan? On the day of the scan eliminate your caffeine intake and try to not take cold medication or aspirin (if you do please write it down on the intake form). Eat as you normally would.

Are there any side effects or risks to the study? The study does not involve a dye and people do not have allergic reactions to the study. The possibility exists, although in a very small percentage of patients, of a mild rash, facial redness and edema, fever and a transient increase in blood pressure. The amount of radiation exposure from one brain SPECT study is approximately 2/3rd of a head CT scan. Rarely, patients have reported green urine after the procedure for a day or two.

How is the SPECT procedure done? The evaluation typically consists of two scans that are performed at least 24 hours apart. Usually, the concentration scan is performed first. The imaging agent is injected through a small intravenous (IV) tube in the arm and the patient is given a task which requires prolonged concentration. On the next scheduled day the resting scan is obtained. During this scan, the patient is placed in a quiet room and the imaging agent is once again started through a small intravenous (IV) tube. During this scan, the patient is asked to relax and allow their mind to wander while they remain quiet for approximately 15 minutes. For both scans, following the injection, the patient lies on a table and the SPECT camera rotates around his/her head (the patient does not go into a tube). The time on the table varies from 15-30 minutes. The study is then read within the next few days. Pictures are made available to the patient's treatment professionals. Please ensure you have a follow-up appointment with a physician to go over the results of the study.

Are there alternatives to having a SPECT study? In our opinion, SPECT is the most clinically useful study of brain function for the indications listed above. There are other studies, such as electroencephalograms (EEGs), Positron Emission Tomography (PET) studies and functional MRIs (fMRI). PET studies and fMRI are considerably more costly and they are performed mostly in research settings. EEGs, in our opinion, do not provide enough information about the deep structures of the brain to be as helpful as SPECT studies.

Do I have to have the SPECT study performed at a specific Clinic? No. SPECT studies may be performed at other clinics. The patient may choose any other facility for this study or any other study or service recommended by our clinic. However, many doctors and patients utilize our services.

Does insurance cover the cost of SPECT studies? Reimbursement by insurance companies varies according to your plan. It is often a good idea to check with the insurance company to see if it is a covered benefit.

Is the use of brain SPECT imaging accepted in the medical community? Brain SPECT studies are widely recognized as an effective tool for evaluating brain function in seizures, strokes, dementia and head trauma. There are literally thousands of research articles on these topics. In our clinic, based on our fifteen years of experience, we have developed this technology further to evaluate neuropsychiatric conditions. Unfortunately, many physicians do not fully understand the application of SPECT imaging and may tell you that the technology is experimental, but over 1,000 physicians and mental health professionals from across the United States have referred patients to us for scans.

Medication History

Your medication history is a very important part of the evaluation. Before your history appointment please answer the following questions about all of the medications you have tried. We include a detailed list below of most psychiatric medication. You can also write this information on a separate piece of paper and attach it to your paperwork prior to meeting with the Historian. The information the doctor needs to know in order to do a through evaluation is:

1. The name of the medication – these are reminders, dosages are helpful for the historical review
2. The mg, dose
3. The amount of tablets or mg you took in one day
4. The approximate dates taken – preferably in sequential order
5. Whether the medicine worked well, worked partially, or didn't work at all.
6. If you took any medications in combination with other medications
7. Any side effects or adverse effects from the medication
8. If any 1st degree relatives have had positive or negative responses from any of the medications below.

ADD Medications

Ritalin *methylphenidate*	Concerta *Methylphenidate*	Dexedrine Spansules *dextroamphetamine*	Desoxyn *methamphetamine HCL*
Ritalin LA *methylphenidate*	Metadate *Methylphenidate*	Dextrostat *dextroamphetamine*	Adderall / Adderall XR *4 amphetamine salts*
Ritalin SR *methylphenidate*	Focalin *Dexmethylphenidate*	Strattera *atomoxetine*	Provigil *modafinil*
Methylin *methylphenidate*	Dexedrine *Dextroamphetamine*	Cylert *pemoline*	Vyvanse Lisdexampfetamine

Antidepressants

Lexapro *escitalopram*	Serzone *Nefazodone*	Norpramin *desipramine*	Surmontil *trimipramine*
Celexa *citalopram*	Effexor / Effexor XR *Venlafaxine*	Tofranil *imipramine*	Vivactil *protrityline*
Prozac *fluoxetine*	Cymbalta *duloxetine HCL*	Elavil *amitriptyline*	Ludiomil *maprotiline*
Zoloft *sertraline*	Wellbutrin / Wellbutrin SR and XL *bupropion*	Pamelor *nortriptyline*	Nardil *phenelzine*
Paxil / Paxil CR *paroxetine*	Remeron *Mirtazapine*	Sinequan *doxepin*	Marplan *isocarboxazid*
Luvox *fluvoxamine*	Desyrel *Trazodone*	Ascendin *amoxapine*	Parnate *tranylcypromine*
Anafranil *Clomipramine hcl*			

Anti-Anxiety Medications

Buspar *buspirone*	Ativan *Lorazepam*	Xanax *alprazolam*	Tranxene *clorazepate*
Valium *diazepam*	Klonopin *Clonazepam*	Serax *oxazepam*	Librium *chlordiazepoxide*

Mood Stabilizers

Lithium / Eskalith *lithium carbonate*	Tegretol / Carbatrol Tegretol XR *carbamazepeine*	Lamictal *lamotrigine*	Keppra *levetiracetam*
Depakene *valproic acid*	Neurontin *Gabapentin*	Topamax *topiramate*	Zonegran *zonisamide*
Depakote *divalproex*	Gabitril *Tigabine*	Trileptal *oxcarbazepine*	Dilantin *phenytoin*
Donnatal *phenobarbital*			

Anti-Psychotic Medications

Risperdal *risperidone*	Seroquel *Quetiapine*	Prolixin *fluphenazine*	Mellaril *molindone*
Geodon *ziprasidone HCL*	Abilify *aripiprazole*	Haldol *haloperidol*	Loxitane *loxapine*
Clozaril *clozapine*	Orap *pimozide*	Navane *thiothixene*	Moban *molindone*
Zyprexa *olanzapine*	Thorazine *chlorpromazine*	Stelazine *trifluoperazine*	Zydis *Olanzapine*
Symbyax *Olanzapine/fluoxetine hcl*			

Anti-Tic Hypertensive Medications

Cataprex *clonidine*	Tenex *guanfacine*	Inderal *propranolol*	

Movement Disorders

Cogentin *benztropine*	Benadryl *diphenhydramine*	Symmetrel *amantadine*	

Memory / Alzheimer's Medications

Aricept *donepezil HCL*	Exelon *revastigmine tartrate*	Reminyl - now Razadyne ER *galantamine HBR*	Namenda *memantine*

Sleep Aid

Ambien *zolpidem tartrate*	Lunesta *Zopiclone*	Sonata *zaleplon*	Desyrel *trazodone*
Rozerem *ramelteon*			

Weight Loss

Meridia *sibutramine hydrochloride monohydrate*	Phentermine *phenethylamine*	Fenfluramine *fenfluramine hydrochloride*	

Sexual Dysfunction

Viagra *sildenafil citrate*	Levitra *Cardenafil hcl*	Cialis *tadalafil*	

Migraine Medications

Esgic plus *butalbital / acetaminophen*	Imitrex *sumatriptan succinate*	Frova *frovatriptan succinate*	Axert *almotriptan malate*
Fiorinal	Fioricet *butalbital / acetaminophen*		

Pain Medications

Vicodin *hydrocodone*	Oxycontin *oxycodone*	Percocet *oxycodone HCI/APAP CII*	Darvon *propoxyphene*
Darvocet *propoxyphene*	Percodan *aspirin / hydrocodone*	Roxanol *(morphine sulfate)*	Avinza (*morphine sulfate – extended release*)
Fentanyl (*fentanyl citrate*)			