



## AAA Neuropsychology, LLC

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Phone: **484-870-5608** · Fax: 484-870-5609

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Thank you for taking the time to read over this information. Of course, please feel free to call our office (484-870-5608) or email ([info@aaaneuropsych.com](mailto:info@aaaneuropsych.com)) if you have any further questions, we would be happy to help!

### **Things to bring to your neuropsychology appointment**

- Photo identification (e.g. driver's license)
- Primary and secondary insurance cards (if applicable)
- Lunch or snack. We have a refrigerator for storage if you need it.
- Hearing aids or reading glasses, if applicable
- Any routine medications you need for the day can be taken.
  - If this is an ADD/ADHD evaluation, we prefer that you NOT take your ADD/ADHD medication on the day of the evaluation since it can affect cognitive test performance, but please check with your doctor first.

Please try to get a good night's rest the night before the evaluation.

Please avoid alcohol and illicit drugs at least 24 hours prior to the evaluation.

**\*\*\*\*PLEASE SUBMIT YOUR COMPLETED FORMS TO [INFO@AAANEUROPSYCH.COM](mailto:info@aaaneuropsych.com) BEFORE YOUR APPOINTMENT\*\*\*\***



**Client Information Form**

**A. Identification:**

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Nicknames or aliases: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Cell: \_\_\_\_\_ Home: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Calls or e-mail will be discreet, but please indicate any restrictions: \_\_\_\_\_  
 Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Please list any family members/loved ones that you authorize us to communicate with here: \_\_\_\_\_  
 \_\_\_\_\_

**B. Referral:** Who gave you our contact information?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Address: \_\_\_\_\_  
 May we thank this person for the referral?  Yes  No  
 How did this person explain how we might be of help to you? \_\_\_\_\_

**C. Providers:** Please list relevant current treatment providers below

	<b>Provider Name</b>	<b>Practice Affiliation</b>	<b>Address</b>	<b>Phone Number</b>	<b>Please check if we can contact for information or records</b>	<b>Please check to release your report to this provider</b>
<b>Primary Care Physician:</b>						
<b>Neurologist:</b>						
<b>Psychiatrist:</b>						
<b>Psychologist/Therapist:</b>						
<b>Other:</b>						

**D. Payment information:** Is this evaluation for treatment planning purposes only?  Yes  No  Not Sure

Please check if you are currently involved or plan to be involved in any of the following situations:

	No	Yes, please briefly explain
Personal injury law suit/litigation		
Worker's compensation claim		
Disability application or appeal		
Fitness for duty evaluation		
School IEP/special education assessment		
Other legal involvement		

**Primary Insurance**

Health insurance carrier/company name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of policyholder (if not the patient): \_\_\_\_\_ Policyholder's date of birth: \_\_\_\_\_

Policyholder's SSN: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Policyholder's address: \_\_\_\_\_ Phone # of provider services (back of card): \_\_\_\_\_

If you have a copay, please indicate amount \$ \_\_\_\_\_ and method of payment \_\_\_\_\_

**Secondary Insurance**

Health insurance carrier/company name: \_\_\_\_\_

Name of policyholder (if not the patient): \_\_\_\_\_ Policy#: \_\_\_\_\_

If you do not have insurance, how will you pay for services from this office? \_\_\_\_\_

**E. Signature:** I attest that the above information is accurate to the best of my knowledge.

Name (printed): \_\_\_\_\_ Witness: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature required by patient if 14 years old or older)

Signature of Authorized Person (if applicable): \_\_\_\_\_ Relationship: \_\_\_\_\_



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## **Informed Consent for Clinical Neuropsychological/Psychological Evaluation**

**Purpose:** You have been referred for a clinical neuropsychological/psychological evaluation. If we are billing your insurance company, this is considered a clinical evaluation for treatment planning purposes only. This type of evaluation is not intended to be used for legal/forensic, vocational, or school purposes. If you plan to use the evaluation for other purposes (e.g., law suits, disability application or appeal, school IEP/special educational evaluation, competence evaluation, work or fitness for duty evaluation, aviation evaluation, vocational evaluation, worker's compensation law suit, other legal involvement), you should notify us ahead of time so that we can conduct an appropriate evaluation for you.

**Examiner:** You will be working primarily with licensed psychologists (neuropsychologists) and their designees. The clinical interview and feedback sessions will be with the doctor; however, a trained psychological assistant may administer some or all the standardized tests under the direct supervision of the psychologist/neuropsychologist.

**Nature of Evaluation:** Neuropsychological/psychological examinations begin with a clinical interview, where questions will be asked about your background and current symptoms/concerns. Most of what you share will be included in a detailed clinical report that will be released to the referral source and others you authorize. Standardized paper-pencil and computer tests may then be administered. These tests measure thinking in areas such as intelligence, attention, memory, language, problem-solving, visuospatial skills, etc. Understanding your personality, emotional and sociocultural functioning is also often part of our evaluations. The length of the evaluation depends on your presenting concerns and your pace. After completing the testing, we typically schedule a feedback session a few weeks later to review your results and discuss our recommendations. The finalized report will then be sent to those you authorize. Throughout the evaluation, your task is to do your best and answer questions accurately, so that we can get a true understanding of your strengths and areas of need.

**Foreseeable Risks, Discomforts, and Benefits:** The results of this examination may either support or not support your concerns. For some individuals, evaluations can cause fatigue, frustration, and anxiousness. Our goal is to minimize these factors, so please let us know so we can try to accommodate your needs.

**Limits of Confidentiality:** When we examine, test, diagnose, treat or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information to decide what assessments or treatments are best for you. We may also share this information with others to arrange payment for your evaluation, to carry out certain business or government functions, or to help provide other services for you. Your PHI will also be accessible by individuals associated with the referral source and their representatives. Information obtained during evaluation is confidential and can ordinarily be released only with your permission. There are some times when the laws require us to use or share your information. For example: 1) when there is a serious threat to your or another's health and safety or to the public (including statements indicating harm or abuse of children or vulnerable adults); 2) when we are required to do so by lawsuits and other legal or court proceedings; 3) if a law enforcement official requires us to do so; and 4) for worker's compensation and similar benefit programs. There are also some other rare situations further described in our notice of privacy practices.

In the event that you or someone on your behalf chooses to post online reviews of our practice, please note that you are publicly acknowledging a provider-client relationship and thus have waived your right to privacy. You should be aware of any potential negative impact that could occur based on this disclosure. Furthermore, the nature of the confidential relationship between you and the provider is known to contribute to the effectiveness of psychological work. Instead, we invite clients to share their comments – either positive or negative directly with us. We are always willing to discuss your reactions and will work with you to make your experience a positive one.

**Recordings:** Test material used during this evaluation is proprietary and confidential. It is not permissible to copy, reproduce, record, transmit, or disclose test materials or content by any means at any time. The use of Artificial Intelligence software like ChatGPT during testing is strictly prohibited. You are required to complete the exam by yourself. It is also prohibited to consult other people on the content of exam questions. During the testing, we may make video or audio recordings of portions for supervision and quality control purposes. If you would like to decline video/audio recordings for these purposes, please let us know in writing.

**Telehealth:** If any part of the evaluation is being conducted remotely using telehealth technologies such as video or telephone conferencing, while most research shows that telepsychology is as effective as in-person services, there are additional risks of remote evaluation, including others overhearing or technology failures. We will take reasonable steps to ensure your privacy, and you should do the same. We try to minimize technology related risks by using a HIPPA compliant platform. If you are having an emergency, do not call us back; instead, call 911, or go to your nearest emergency room. Call us back after you have called or obtained emergency services. Please note that recordings of the remote session through screen capture and video/audio recording is strictly prohibited.

**Billing, Financial and Office Policies:** Your clear understanding of our billing, financial and office policies is important to our professional relationship. Please ask if you have any questions about payment for our services, our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any changes (i.e., address, name, insurance, etc.).

- **Co-pays:** All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with us. We currently accept cash, check, or credit card payments.
- **Insurance Claims:** Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. To properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in your responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for any part of your services performed at our office, you are responsible for the complete balance of the non-payable services. We will send you a bill. If we are out of network with your insurance company and your insurance pays you directly, you are still responsible for payment and agree to forward the payment to us immediately.

As a reminder, this type of evaluation is not intended to be used for legal/forensic, vocational, school, or non-medically necessary purposes. If you do not notify us and we conduct an evaluation that is not considered medically necessary or bill for non-covered services you could be committing insurance fraud with your insurance carrier. Since we are notifying you in advance, AAA Neuropsychology relinquishes responsibility from any future actions taken for fraudulent or misuse of the terms and policies of your contract with your insurance company.

- **Workers' Compensation and Automobile Accidents:** In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier/adjuster prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service. Again, if the claim is not paid to us, we will send you a bill that you are responsible to pay.
- **Missed Appointments:** We require 2-business day notice of appointment cancellation or rescheduling. Appointments missed without 2-business day notification may be charged a fee of \$150.00 for an intake or feedback appointment and \$300 for a testing appointment. Our office has a 3 strikes policy for no-shows, after which we may not reschedule your appointment.
- **Outstanding Balance Policy:** It is our office policy that all past due accounts be sent at least 2 statements. If payment is not made on your account, a phone call will be made to try to make payment arrangements. If no resolution can be made, the account may be sent to a collection agency or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.
- **Other Fees:** We charge a minimum \$25 fee for every page of additional paper-work or clinical letters that we are asked to complete on your behalf beyond the clinical report we will prepare for the referral source. Clinical evaluations also do not include extensive record reviews, so we charge an hourly rate for any records (beyond 15 pages of clinical notes) that we are asked to review. We also charge our standard record retrieval and copying fees for report requests 30 days after completion of our clinical evaluation.

**Consent:**

- I hereby give my consent for AAA Neuropsychology to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).
- With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.
- With this consent, the Practice may email or mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements, evaluation reports, and anything pertaining to my clinical care if they are sent securely.
- I consent to participation in neuropsychological/psychological care.
- I give this office permission to release any information obtained during my care that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.
- I understand that I am ultimately responsible for all payments and charges, regardless of insurance coverage.
- I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the Practice. Medicare regulations may apply.
- I am aware that an agent of my insurance company, third-party payer, and this professional's insurance administrator may be given information about the type(s), cost(s), date(s), and providers of any services or treatment I receive. I authorize payment directly to this professional within this Practice. I authorize the use of this signature on all my insurance submissions.
- I have read or heard of our notice of privacy practices, which explains more detail about my rights and how we can use and share your information.
- A photocopy of this assignment is to be considered as good as the original.
- This assignment will remain in effect until revoked by me in writing.
- In consideration of consent, I hereby release the source of the records from any and all liability arising there from.
- I have read and agree with the aforementioned areas in this document. I have had an opportunity to clarify any questions and discuss any points of concern before signing.
- I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

Name (printed): \_\_\_\_\_ Witness: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Authorized Person (if applicable): \_\_\_\_\_ Relationship: \_\_\_\_\_



Neuropsychological/Psychological Intake Form - Adult Form

Please complete this form to the best of your abilities. Your responses will provide us with information that will help us get to know you and your background. We are particularly concerned about characteristics or experiences that can affect thinking abilities and emotional well-being. Please answer the questions honestly. Information will be kept confidential as indicated in the privacy notice. We will review this form with you, and you will have a chance to discuss your answers and clarify any questions. Thank you! **\*\*\*\*PLEASE SUBMIT YOUR COMPLETED FORMS TO [INFO@AAANEUROPSYCH.COM](mailto:INFO@AAANEUROPSYCH.COM) BEFORE YOUR APPOINTMENT\*\*\*\***

**A. Basic Identification**

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Pronouns: \_\_\_\_\_  
Ethnicity: \_\_\_\_\_ Handedness: \_\_\_\_\_ Native language: \_\_\_\_\_

**B. Medical and Neurological History**

Please list your current medical diagnoses: \_\_\_\_\_  
\_\_\_\_\_

Please list any surgeries and dates: \_\_\_\_\_

List *all* Medications you are currently taking or have taken in the last year. If you have a list, you can provide a copy.

Medication      Dose      How often?      Date started?      Reason to take it?      Prescribed by?      Is it effective?

List any Vitamins/Supplements that you are currently taking: \_\_\_\_\_

List any other relevant medications taken in the past: \_\_\_\_\_

Have you had any of the following general *medical problems*? Check all that apply and specify when they started.

<input type="checkbox"/> Allergies or asthma. Specify:	<input type="checkbox"/> Heart attack, heart failure or any other heart disease (please circle)
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High cholesterol
<input type="checkbox"/> High blood sugar or diabetes	<input type="checkbox"/> Liver disease, hepatitis, cirrhosis, or jaundice
<input type="checkbox"/> Kidney disease or dialysis	<input type="checkbox"/> Thyroid disease or other endocrine (gland) disorder
<input type="checkbox"/> Vitamin deficiency. Specify:	<input type="checkbox"/> Cancer. Specify:
<input type="checkbox"/> Pain. Specify:	<input type="checkbox"/> Exposure to toxic chemicals

Other medical problems \_\_\_\_\_

Have you had any of the following neurological problems? Please indicate all that apply.

<input type="checkbox"/> Head injury or concussion	<input type="checkbox"/> Loss of oxygen, choking, drowning, or suffocation
<input type="checkbox"/> Seizures, epilepsy, or "fits"	<input type="checkbox"/> Drug or alcohol overdose
<input type="checkbox"/> Stroke, brain hemorrhage, "TIA's" or other vascular problem	<input type="checkbox"/> Headaches or migraines
<input type="checkbox"/> High fever, meningitis, encephalitis, or other brain infection	<input type="checkbox"/> Parkinson's disease, tremors, movement problems
<input type="checkbox"/> Fainting or dizzy spells	<input type="checkbox"/> Alzheimer's disease or other dementia
<input type="checkbox"/> Brain tumor or cyst	<input type="checkbox"/> Multiple sclerosis or other demyelinating disease

<input type="checkbox"/> Balance problems or falls <input type="checkbox"/> Tremors, dexterity problems, numbness <input type="checkbox"/> Broken bones or injuries <input type="checkbox"/> Vision problems (e.g. blurred/double/floaters/sensitivity) <input type="checkbox"/> Hearing problems (e.g. sensitivity/ringing/interference) <input type="checkbox"/> Taste changes (e.g. unusual/unexpected tastes)	<input type="checkbox"/> Smell problems (e.g. difficulty identifying odors, unusual/unexpected smells) <input type="checkbox"/> Temperature regulation problems (e.g. feeling hot or cold all the time) <input type="checkbox"/> Changes in sexual interest, ability or activity <input type="checkbox"/> Incontinence with bladder or bowels
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Have you had any of these diagnostic tests?

Brain MRI  Date \_\_\_\_\_ Results \_\_\_\_\_

Brain CT  Date \_\_\_\_\_ Results \_\_\_\_\_

Brain EEG  Date \_\_\_\_\_ Results \_\_\_\_\_

Labs  Date \_\_\_\_\_ Results \_\_\_\_\_

Sleep Study  Date \_\_\_\_\_ Results \_\_\_\_\_

Are you satisfied with your sleep?  No  Yes. # hours of sleep/night \_\_\_\_\_ # daytime naps \_\_\_\_\_

Do you exercise regularly?  No  Yes. If yes, how often? \_\_\_\_\_ What type of exercise? \_\_\_\_\_

Do you wear glasses/contacts?  No  Yes Do you wear hearing aids?  No  Yes

Do you use a cane/walker/wheelchair?  No  Yes Are you in pain?  No  Yes

### **C. Family Medical History**

Mother: Alive?  No  Yes Age (or age at death): \_\_\_\_\_ Health problems?: \_\_\_\_\_ Job: \_\_\_\_\_

Father: Alive?  No  Yes Age (or age at death): \_\_\_\_\_ Health problems? \_\_\_\_\_ Job: \_\_\_\_\_

Brother(s): #: \_\_\_\_ Age(s): \_\_\_\_\_ Health problems? \_\_\_\_\_ Sister(s): #: \_\_\_\_ Age(s): \_\_\_\_\_ Health? \_\_\_\_\_

Your birth order: \_\_\_\_\_ of \_\_\_\_\_

Children: Names & ages: \_\_\_\_\_

Do your children have any behavioral or medical problems?  No  Yes. Specify: \_\_\_\_\_

Does anyone in your *biological family* have a history of the following? Indicate all that apply

<input type="checkbox"/> Seizures, epilepsy, or "fits" <input type="checkbox"/> Stroke, brain hemorrhage, "TIA's" or other vascular problem <input type="checkbox"/> Heart attack or heart failure or heart disease <input type="checkbox"/> Parkinson's disease or other movement disorder <input type="checkbox"/> Alzheimer's disease or other dementia <input type="checkbox"/> Multiple sclerosis or autoimmune disorder <input type="checkbox"/> Genetic disorders <input type="checkbox"/> Liver, kidney or lung disease	<input type="checkbox"/> Diabetes, thyroid disease or other endocrine (gland) disorder <input type="checkbox"/> Cancer <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Learning disability <input type="checkbox"/> Developmental delays or autism spectrum <input type="checkbox"/> Emotional problems (e.g. depression, anxiety, schizophrenia, bipolar, OCD) <input type="checkbox"/> Problems with drugs or alcohol
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Other serious medical or emotional problem? Specify: \_\_\_\_\_

### **D. Psychological History** Have you ever experienced any of the following?

<input type="checkbox"/> Depression or sad mood <input type="checkbox"/> Suicidality or self-harm <input type="checkbox"/> Angry outbursts or irritability <input type="checkbox"/> Anxiety or stress <input type="checkbox"/> PTSD or trauma <input type="checkbox"/> Phobias or fears <input type="checkbox"/> Obsessions/compulsions (OCD) <input type="checkbox"/> Elated mood or mania	<input type="checkbox"/> Eating disorder (e.g. anorexia, bulimia) <input type="checkbox"/> Hallucinations (seeing/hearing/feeling things that others don't) <input type="checkbox"/> Delusions (strong beliefs that most others don't share) <input type="checkbox"/> Conversion or somatic symptoms <input type="checkbox"/> Relationship or interpersonal problems <input type="checkbox"/> Social difficulties <input type="checkbox"/> Cultural stress (e.g. racism, sexism, ableism, heterosexism, classism) <input type="checkbox"/> Acculturation stress (e.g. immigration related)
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Other emotional difficulties. Specify: \_\_\_\_\_



Have you ever been hospitalized for psychiatric reasons? No Yes. Specify: \_\_\_\_\_

Have you ever had psychological or neuropsychological testing before? No Yes. Specify: \_\_\_\_\_

Have you ever received psychological, psychiatric or counseling services before? No Yes. Please specify below:

When?

From whom?

For what?

With what results?

Do you consume coffee, soda, tea, or other sources of caffeine regularly? No Yes. # cups/cans per day \_\_\_\_\_

Do you use tobacco? No Yes. Amount per day \_\_\_\_\_ If no, did you quit in the past? No Yes. When? \_\_\_\_\_

Do you drink alcohol? No Yes Did you quit in the past? No Yes. When? \_\_\_\_\_ Current # drinks/week: \_\_\_\_\_

Do you use cannabis or marijuana? No Yes Did you quit in the past? No Yes. Current use/day: \_\_\_\_\_

Have you ever used illicit drugs? No Yes. Specify \_\_\_\_\_

Do you have any DUIs or neglected work/family responsibilities due to your drug or alcohol use? No Yes

### **E. Developmental History**

Which city/state/country were you born in? \_\_\_\_\_

If born outside the US, when immigrated to the US? \_\_\_\_\_

Do you speak, read, or write in any other languages? \_\_\_\_\_

What language do you prefer to do your evaluation in? \_\_\_\_\_

During your *mother's pregnancy* with you, did your mother have any of the following medical problems?

<input type="checkbox"/> Required bedrest or hospitalization for medical problems	<input type="checkbox"/> Suffered a serious physical injury
<input type="checkbox"/> Used alcohol, tobacco, or non-prescription drugs	<input type="checkbox"/> Other _____
<input type="checkbox"/> Used prescribed medication other than vitamins	<input type="checkbox"/> No problems during mother's pregnancy
<input type="checkbox"/> Was exposed to lead, solvents, or other toxic substances	<input type="checkbox"/> I don't know

During *your birth*, were there any of the following problems or complications?

<input type="checkbox"/> Born prematurely	<input type="checkbox"/> Treated in Intensive Care Unit after your birth
<input type="checkbox"/> Had the cord wrapped around your neck at birth	<input type="checkbox"/> Other birth complications
<input type="checkbox"/> Lack of oxygen or other fetal distress	<input type="checkbox"/> No problems during my birth
<input type="checkbox"/> Low "APGAR" scores (poor vital signs at birth)	<input type="checkbox"/> I don't know

Did you experience any of the following delays in your *development* as a child?

<input type="checkbox"/> Walking late (after 1 ½ year of age)	<input type="checkbox"/> Social delays
<input type="checkbox"/> Talking late (after 2 years of age)	<input type="checkbox"/> Other delays
<input type="checkbox"/> Bedwetting (after 5 years of age)	<input type="checkbox"/> Typical developmental milestones
<input type="checkbox"/> "Tics" (involuntary movements/sounds such as grunting)	<input type="checkbox"/> I don't know

Do you have a childhood history of any of the following (known or suspected)?

<input type="checkbox"/> Head injury or concussions	<input type="checkbox"/> Learning disabilities
<input type="checkbox"/> Seizures	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Speech problems	<input type="checkbox"/> Speech Therapy
<input type="checkbox"/> Autism spectrum disorder	<input type="checkbox"/> Physical Therapy
	<input type="checkbox"/> Occupational Therapy

How would you describe your childhood home? (check all that apply)

Happy Calm Stressful Abusive Neglectful Fearful Unstable Parental divorce or separation Other

If you are aware, how was your childhood temperament described?

Happy Easy Cranky Withdrawn Shy Scared I don't know Other \_\_\_\_\_

Have you experienced any of the following ? Physical abuse Sexual abuse  Emotional abuse Neglect Not sure  
Other \_\_\_\_\_

**F. Educational History** Please briefly list information about your *high school and/or college/trade schools*

School Name                      Graduation Year                      Grades/~GPA                      Major                      Degree                      Any accommodations?

Best subject(s): \_\_\_\_\_ Worst subject(s): \_\_\_\_\_ Required tutoring/special support? No Yes  
Failed or repeated any grades? No Yes \_\_\_\_\_ Known SAT/standardized test scores? \_\_\_\_\_  
Had/have IEP or 504 plan? No Yes \_\_\_\_\_ Specify: \_\_\_\_\_

**G. Occupational History**

Are you currently Employed: No Yes.  
 Full time work  Part time work  Retired  Student  Government assistance  Short/long term disability  
 Unemployed  Homemaker  Other

Briefly describe your *current and past employment* history:

Dates of employment    Place of employment                      Job Title                      Job Duties                      Any job problems?

Have you done any kind of work where you were exposed to toxic chemicals?  No  Yes. Specify: \_\_\_\_\_

Military Service? No Yes    Service Branch: \_\_\_\_\_ Rank at discharge: \_\_\_\_\_ Position: \_\_\_\_\_  
Year of enlistment: \_\_\_\_\_ Year of discharge: \_\_\_\_\_ Honorable discharge?  No  Yes.    Combat? No Yes

**H. Social History**

Current living arrangement: Independent Roommate With partner With children With parent  Other \_\_\_\_\_

Are you currently in a romantic relationship? No Yes.    How long? \_\_\_\_\_

Are you married?    No Yes. How long?: \_\_\_\_\_    Prior divorces? No Yes. # of times: \_\_\_\_\_ When? \_\_\_\_\_

Would you describe your current marriage/relationship as Supportive Neutral Stressful Destructive Other

Are there any other aspects of your identity that you would like to share with us to help us understand you better (e.g. spiritual/religious, LGBTQ2+, indigenous heritage)? \_\_\_\_\_

What are your hobbies/interests? \_\_\_\_\_

What do you consider to be your strengths? \_\_\_\_\_

What is your biggest challenge/stressor right now? \_\_\_\_\_

Who do you consider to be part of your support network? \_\_\_\_\_

Do you have an Advanced Directive, Living Will and/or Durable Power of Attorney? No Yes Unsure

Did you complete this form Independently or were you Helped by someone? Specify who \_\_\_\_\_

***Thank you for providing this information. We will meet with you to discuss this form further. \*\*\*\*PLEASE SUBMIT YOUR COMPLETED PACKET TO [INFO@AAANEUROPSYCH.COM](mailto:INFO@AAANEUROPSYCH.COM) BEFORE YOUR APPOINTMENT\*\*\*\****