



AAA Neuropsychology, LLC

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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) 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 or passport)
- Primary and secondary insurance cards (if applicable)
- Form of Payment
- 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*****

Delay in the return of these forms could result in rescheduling or cancelling of 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: _____

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

	Provider Name	Practice Affiliation	Address	Phone Number	Please check if we can contact for information or records	Please check to release your report to this provider
Primary Care Physician:						
Neurologist:						
Psychiatrist:						
Psychologist/Therapist:						
Other: (i.e. providers/family members/loved ones/support persons)						

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

Please check Yes or No 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: _____



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 the PHI 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 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.

Minor Consent: In accordance with Pennsylvania law, minors who are 14 years of age or older have the legal right to consent to their own voluntary outpatient mental health treatment. Parental or legal guardian consent is not required. If the minor provides consent, they may also determine what information, if any, may be shared with their parent or legal guardian. If a parent or legal guardian consents to treatment for a minor under the age of 18, they are entitled to receive information necessary to make informed decisions, including details about the symptoms and conditions being treated, therapies, and the potential risks, benefits, and expected outcomes of treatment. In cases where both the minor (age 14 or older) and the parent or legal guardian have the legal right to consent, neither party's decision can override the other's with regard to outpatient

treatment. This consent form acknowledges that you have been informed of these rights and responsibilities as they relate to minor consent for mental health treatment in the Commonwealth of Pennsylvania.

Recordings: Test materials used during this evaluation are proprietary and confidential. The copying, reproduction, recording, transmission, or disclosure of any test materials or content by any means is not permitted. The use of Artificial Intelligence (AI) software or tools by the examinee during testing is strictly prohibited. You are required to complete all testing independently and may not seek assistance or consult with others regarding test content or questions. During testing, AAA Neuropsychology may utilize AI-powered clinical support tools and may audio and/or video record portions for purposes of supervision, quality assurance, and to support your care. If you prefer not to have any recordings made for these purposes, please inform us 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, text, or email me to my home or other alternative location and leave a message by voice, email, text, 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 the Practice 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 - Adolescent 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 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: _____

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
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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)
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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 school or other 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"/> Had forceps used during your delivery	<input type="checkbox"/> No problems during my birth
<input type="checkbox"/> Lack of oxygen or other fetal distress	<input type="checkbox"/> I don't know
<input type="checkbox"/> Low "APGAR" scores (poor vital signs at birth)	

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 temperament in infancy and toddlerhood? (e.g. anxious, easy, cranky, happy, shy, withdrawn, fearful) _____

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

E. Educational History

Preschool:

Parent or Teacher Concerns? Y / N If yes, please specify: _____

Any evaluations or Early Intervention? Y / N If yes, please specify: _____

Elementary School:

School Name(s): _____

Grades in Reading ___ Writing ___ Math ___ Science ___ History ___

Parent or Teacher Concerns? Y / N If yes, please specify: _____

Repeated any grades? Y / N If yes, please specify: _____

Middle/Junior High School:

School Name(s): _____

Grades in Reading ___ Writing ___ Math ___ Science ___ History ___

Organizational / Time Management Problems? _____

Parent or Teacher Concerns? _____

Repeated any grades? Y / N If yes, please specify: _____

Any evaluations, 504, IEP, tutoring, other support? Y / N If yes, please specify and note dates:

High School

School Name(s): _____

Grades in Reading ___ Writing ___ Math ___ Science ___ History ___

Organizational / Time Management Problems? _____

Current Overall GPA: _____

Parent or Teacher Concerns? Y / N If yes, please specify: _____

Repeated any grades? Y / N If yes, please specify: _____

Any evaluations, 504, IEP, tutoring, other support? Y / N If yes, please specify and note dates:

Known SAT/standardized test scores? _____

College

School Name(s): _____

What are your strongest subjects? _____ Weakest subjects? _____

Organizational / Time Management Problems? _____

Current GPA: _____

Any Accommodations (please specify): _____

G. Work History

Currently Employed: No Yes.

Full time work Part time work Student Government assistance Short/long term disability

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

H. Social History

Current living arrangement: Independent Roommate With partner With children With parent Other _____

How many hours of screen time do you engage in per day? _____ What type of content? _____

Are you currently involved in a romantic relationship? No Yes. How long? _____

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

Are you involved in any extracurricular activities? No Yes. Which ones? _____

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? _____

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 BEFORE YOUR APPOINTMENT*******