GILBERT NEUROLOGY

Check In Time & Date_____

Dear Patient,
You have been referred for a neuropsychological evaluation at Gilbert Neurology. Your appointment is with clinical neuropsychologist, Ted W. Etling PsyD at the address and suite below. This type of evaluation is part of the full neurological work up and assesses your cognitive/thinking skills. The evaluation results provide key information that will assist your neurologist in making treatment decisions.

- The evaluation will take generally 2 to 2 ½ hours, so you may bring snacks and/or something to drink. Evaluations for those patients who are under 60 years old can sometimes take approximately 3 hours.
- If you wear glasses, even reading glasses, bring them to the evaluation.
- If you have hearing aids, it is important that you wear them.
- If you bring your cell phone, it should be turned off or placed on vibrate during testing.
- ***It is important to complete the enclosed paperwork prior to the appointment or arrive at your appointment 20 minutes early to fill out the forms in our office.***

Please call us as soon as possible if you need to reschedule or cancel as it takes a considerable amount of time to fill the time slot with another patient (480-926-0644). ***No shows or cancellations less than 24 hours before the appointment time are subject to a $150.00 cancellation charge***.

We look forward to participating in your healthcare. Please do not hesitate to call us if you have any questions about the appointment.

Gilbert Neurology
Department of Neuropsychology
480-926-0644 Ext: 1008
480-926-0645 fax

We have two different office locations and you are scheduled at:

7400 S. Power Rd. Ste. 120 Gilbert, AZ 85297
(Cross Streets: Power/Rittenhouse)

GILBERT NEUROLOGY
7400 S. POWER RD., SUITE 120
GILBERT, AZ. 85297
TED W. ETLING PsyD/NEUROPSYCHOLOGIST

Patient Name: _____

Date of Birth: _____ Age: _____

MARITAL STATUS: _____

HOW MANY CHILDREN? _____ THEIR AGES: _____

DO ANY LIVE IN AZ? _____ HOW MANY? _____

WHO DO YOU LIVE WITH? _____

HOW FAR DID YOU GO IN SCHOOL? Circle: (GED/High School/2-year or 4-year College Degree Masters/Doctorate)

ANY LEARNING DISABILITIES/WHAT SUBJECTS? _____

WHAT KIND OF WORK HAVE YOU MAINLY DONE? _____

ARE YOU APPLYING OR HAVE YOU APPLIED FOR DISABILITY? _____

WHAT IS YOUR DISABILITY? _____

WAS YOUR DISABILITY CASE GRANTED? YES/NO ARE YOU APPEALING THE DECISION? YES/NO

DO YOU EXERCISE? _____DO YOU SOCIALIZE? _____

WHICH HAND DO YOU WRITE WITH? _____

MILITARY SERVICE? YES/NO EXPOSURE TO BOMB BLASTS? YES/NO DIRECT COMBAT? YES/NO

ARE YOU FORGETING RECENT CONVERSATIONS OR REPEATING YOURSELF FREQUENTLY? YES/NO

ARE YOU GETTING LOST DRIVING OR GOING TO FAMILIAR PLACES? ` YES/NO

ARE YOU FORGETTING FAMILY/FRIENDS NAMES OR FACES? `` YES/NO

ARE YOU HAVING DIFFICULTY PAYING ATTENTION OR EASILY DISTRACTED? YES/NO

ARE YOU HAVING DIFFICULTY COMNG UP WITH NAMES OF COMMON OBJECTS? YES/NO

ARE YOU SEARCHING MORE FOR WORDS/LOTS OF PAUSES COMING UP WITH WORDS? YES/NO

ARE YOU HAVING DIFFICULTIES UNDERSTANDING/COMPREHENDING INSTRUCTIONS? YES/NO

ARE YOU HAVING DIFFICULTIES SOLVING PROBLEMS OR REASONING? ` YES/NO

ARE YOU HAVING PROBLEMS WITH DECISION MAKING OR SOUND JUDGMENT? YES/NO

HAS YOUR VISUAL PERCEPTION CHANGED? YES/NO

HAS YOUR SENSE OF TASTE OR SMELL CHANGED? YES/NO

HAS HEARING OR SIGHT CHANGED? YES/NO

HOW LONG HAVE YOU NOTICED CHANGES TO YOUR THINKING SKILLS?_____

ARE THERE ANY BIOLOGICAL FAMILY MEMBERS WHO HAVE/HAD DEMENTIA/ALZHEIMERS

OR BEEN CLASSIFIED AS SENILE? YES/NO

DID YOUR COGNITIVE/THINKING SKILLS CHANGE QUICKLY/ABRUPTLY OR GRADUALLY? (PLESSE CIRCLE)

HAVE THESE SYMPTOMS WORSENED OVER TIME/STAYED THE SAME/IMPROVED? (PLEASE CIRCLE)

PLEASE CIRCLE EACH OF THE FOLLOWING THAT HAVE BEEN DIAGNOSED:

ADHD/ADD
ANEURYSM
BRAIN SURGERY/SHUNT
BRAIN TUMOR
COVID
COMA
CHEMO
CHRONIC KIDNEY DISEASE
DEMENTIA/ALZHEIMERS
DEMENTIA/LEWY BODIES
DIZZINESS
DOUBLE VISION
ENCEPHALITIS/MENINGITIS
EXPOSURE BOMB BLASTS
EXPOSURE TO HEAVY METALS
FAINTING/SYNCOPE
FREQUENT FALLS
GENERAL ANESTHESIA (RECENT)
HYDROCEPHALUS/NPH
HEPATITIS
HEAD INJURY/CONCUSSION
HIV/AIDS
MULTIPLE SCLEROSIS
MIGRAINE
PARKINSONS DISEASE
STROKE/CVA
SLEEP APNEA
SEIZURES/EPILEPSY
TIA/MINI STROKE
TRANSIENT GLOBAL AMNESIA/TGA
TREMORS
URINARY TRACT INFECTIONS
VITAMIN D OR B12 DEFICIENT
OTHER NEUROLOGICAL CONDITIONS

HAVE YOU EVER HAD AN EVALUATION OF THIS TYPE (NEUROPSYCHOLOGICAL) BEFORE? YES/NO

CIRCLE ALL PRIOR NAND CURRENT MENTAL HEALTH DIAGNOSES:

ANXIETY
ALCOHOLISM
BIPOLAR DISORDER
DEPRESSION
DELUSIONS
FEAR OF SOCIAL SITUATIONS
HALLUCINATIOINS (VISUAL/HEARING THINGS)
HOMOCIDAL/SUICIDAL IDEAS
OCD
PTSD (Post-Traumatic stress disorder)
PERSONALITY CHANGES
PERSONALITY DISORDER
PARANOIA
PRESCRIPTION ABUSE
SCHIZOPHRENIA
SUBSTANCE ABUSE
OTHER PSYCHIATRIC DIAGNOSES TYPE_____

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC DISTRESS OR REASONS? YES/NO
EXPLAIN:_____
_____

DO YOU SEE A PSYCHOLOGIST OR COUNSELOR/TALK THERAPY? YES/NO

DO YOU SEE A PSYCHIATRIST? YES/NO

DO YOU TAKE MEDICATION FOR MOOD OR AANXIETY OR OTHER PSYCHIATRIC REASONS? YES/NO

DO YOU TAKE MEDICATION FOR DELUSIONS OR HALLUCINATIONS? YES/NO

DO YOU HAVE INSOMNIA? YES/NO
HOW MANY HOURS OF SLEEP IS NORMAL PER NIGHT FOR YOU? _____

DO YOU ACT OUT IN YOUR SLEEP? (CIRCLE: KICKING, SCREAMING, RUNNING, PUNCHING, SHOUTING, AND/OR RE-ENACTING DREAMS)?

HOW MUCH ALCOHOL DO YOU CONSUME ON A WEEKLY BASIS? _____

DO YOU EXERCISE WEEKLY YES/NO
DO YOU SOCIALIZE OR PREFER TO STAY HOME? _____