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: 7002
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/Ted W. Etling PsyD
7400 S. Power Rd, Ste. 120
Gilbert, Az. 85297
480-926-0644 (o) 480-926-0645 (f)

Patient Name:____

Date of Birth:______________________Age:____________________

Marital Status:____

How many children:____________How many live in Arizona:____________

Who do you live with:_______________________________________

How much schooling did you complete: Circle (GED/High School, 2 yrs. College, 4 yrs. College, Masters, Doctorate).

Any learning disabilities/What topics:_____________

Are you retired:_______ What kind of work have you done or still do:____________

____

Have you applied for disability:______ Was it granted:_____ Have you appealed the decision:_____ What disability did you claim when applying for disability:___________

____

Which hand do you write with:____________ Do you exercise:______________

Do you socialize:____________ Any military service:____________________

Any exposure to combat:______ Any exposure to explosions/bomb blasts:__________

- ARE YOU FORGETTING CONVERSATIONS OR REPEATING YOURSELF OFTEN: Y/N
- ARE YOU GETTIJNG LOST DRIVING OR MISPLACING ITEMS: Y/N
- ARE YOU FORGETTING FAMILY/FRIENDS NAMES AND/OR FACES: Y/N
- ARE YOU HAVING DIFFICULTY PAYINMG ATTENTION/GETTING DISTRATCED: Y/N
- ARE YOU HAVING DIFFICULTY NAMING COMMON OBJECTS: Y/N
- ARE YOU SEARCHING MORE FOR WORDS OR PAUSING MORE WHEN TALKING: Y/N
- ARE YOU HAVING TROUBLE UNDERSTANDING INSTRUCTIONS/DIRECTIONS: Y/N
- ARE YOU HAVING DIFFICULTIES WITH DECISION MAKING/REASONING: Y/N
- ARE YOU HAVING DIFFICULTIES PROBLEM SOLVING OR WITH JUDGEMENT: Y/N
- ARE YOU HAVING DIFFICLTIES WITH VISUAL PERCEPTION: Y/N
- HAS HEARING AND/OR SIGHT CHANGED: Y/N
- HAS TASTE AND/OR SMELL CHANGED: Y/N

- HOW LONG HAVE YOU NOTICED THE ABOVE CHANGES:______________________
- WAS THE CHANGE GRADUAL OR ABRUPT/QUICK:__________________________
- HAVE THESE CHANGES IN THINKING SKILLS WORSENED OVER TIME: Y/N__________
- STAYED THE SAME OVER TIME: Y/N____________________________________
- GOTTEN BETTER OVER TIME: Y/N_____________________________________
- **ANY FAMILY MEMBERS WITH DEMENTIA/ALZHEIMER'S?_____________________**

PLEASE CIRCLE ALL THAT YOU HAVE BEEN FORMALLY DIAGNOSED WITH:

ADHD
ANEURYSM
BRAIN SURGERY
BRAIN TUMOR
COVID
COMA
CHEMO
CHRONIC KIDNEY DISEASE
DEMENTIA/ALZHEIMER'S
DEMENTIA/LEWY BODIES
DIZZINESS
DOUBLE VISION
ENCEPHALITIS/MENINGITIS
EXPOSURE TO EXPLOSIONS
EXPOSURE TO HEAVY METALS
FAINTING/SYNCOPE

FREQUENT FALLS
GENERAL ANESTHESIA
HYDROCEPHALUS/NPH
HEPATITIS
HEAD INJURY/CONCUSSION
HIV/AIDS
MULTIPLE SCLEROSIS
MIGRAINE
PARKINSON'S DISEASE
STROKE/CVA
SLEEP APNEA
SEIZURES/EPILEPSY
TIA/MINI STROKE
TRANSIENT GLOBAL AMNESIA/TGA
TREMORS
URINARY TRACT INFECTIONS

VITAMIN B12 AND/OR D DEFICIENCY
FRONTAL TEMPORAL DEMENTIA
VASCULAR DEMENTIA
MILD COGNITIVE IMPAIRMENT
OTHER NEUROLOGICAL CONDITIONS

Any prior neuropsychological evaluations: _________ By whom: __________________

MENTAL HEALTH HISTORY:

ANXIETY
ALCOHOLISM
BIPOLAR DISORDER
DEPRESSION
DELUSIONS
FEAR OF SOCIAL SITUATIONS
HALLUCINATIONS (visual/voices)
OCD

PTSD
PERSONALITY DISORDER
PERSONALITY CHANGES
PARANOIA
PRESCRIPTION ABUSE
SCHIZOPHRENIA
SUBSTANCE ABUSE
OTHER:_________________________________

- HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC DISTRESS/SUICIUDAL AND/OR HOMOCIDAL IDEAS: Y/N IF SO, WHERE AND WHEN_____________________________
  ____

- DO YOU HAVE A PSYCHIATRIST: Y/N ____
- DO YOU HAVE A PSYCHOLOGIST/COUNSELOR: Y/N________________________________

- DO YOU HAVE INSOMNIA: Y/N____ HOW MANY HOURS DO YOU SLEEP AT NIGHT:______
- DO YOU KICK/SCREAM/PUNCH/HIT/RUN/SHOUT IN YOUR SLEEP OR RE-ENACT DREAMS: (CIRCLE)____
- HOW MUCH ALCOHOL DO YOU CONSUME WEEKLY: ________________________________