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, **Tamara Fisher 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
1452 North Higley Road
Gilbert, AZ 85234
(Cross Streets: Higley/Baseline)
Behind Massage Envy

Gilbert Neurology
1452 N. Higley Road
Gilbert, AZ 85234
480-926-0644 office
480-926-0645 fax

GILBERT NEUROLOGY

Tamara Fisher, Psy.D., Clinical Neuropsychologist

Patient Name:____
Questionnaire Completed by: ______________________________________
Relationship to Patient (circle) Spouse/Partner Child Sibling Friend Caregiver Attorney

Patient Background Information

Age: _____ Date of Birth______________ Gender ____________ Ethnicity________________
Native Language: _____________________ Preferred Language: ______________________
Marital Status (circle) Married Divorced Never Married Widow Years_______
How many times have you been married?____
If you have children, how many?_______ Do they live in Arizona? (Yes / No) _______________

Which hand do you write with? ______________ Did you ever change from one hand to the other? (YES/NO)

If left-handed, is anyone else in your family left-handed (*Father, mother, grandparents, siblings*)? (YES/NO) If so, who?

____

Do you live in a house, condo, apartment, group home, or assisted living? ________________
Who do you live with? ____
What kind of work do you currently do ***or*** have done? ______________________________
Are you retired? (YES/NO) If so, at what age did you retire? __________________________
Have you applied for disability benefits? (YES/NO)
Was your application for benefits granted? (YES/NO) Or is the application pending? (YES/NO)
What medical or psychiatric diagnoses were the reason for going on disability?______________
____

Have you served in the military? ________ If so, what branch?_____________ and how many years?___
Were you deployed to a combat zone? ______________________
Have you been exposed to: (Agent Orange, heavy metals, chemical agents, IED's/bomb blasts)? (Yes/No)

EDUCATION

How far did you go in school? (Circle all that apply) *High School Diploma, GED, Undergraduate College Degree (2-year degree or 4-year degree), Master's degree, Doctorate Degree.*
If you did not finish high school, what grade did you last complete?_____________________
What was the reason or reasons you left school early?______________________________
Were you ever in special education classes? (YES/NO) If so, which classes did you need assistance with?____

MEDICAL HISTORY

Are you experiencing:

Memory loss of recent conversations and/or events? (YES/NO)
Misplacing Items? (YES/NO)
Forgetting names of familiar people? (YES/NO)
Forgetting faces of familiar people? (YES/NO)
Problems with paying attention or getting easily distracted? (YES/NO)
Problems finding words/pauses during conversations? (YES/NO)
Problems finding words or names of common objects? (YES/NO)
Understanding words or instructions? (YES/NO)
Difficulties problem solving or reasoning? (YES/NO)
Difficulties with decision making or using sound judgement? (YES/NO)
Difficulties with visual perception? (YES/NO)
Problems with the sense of taste and/or smell (YES/NO)
Problems with the sense of vision and/or hearing? (YES/NO)

With regard to the changes in thinking skills above, *how* many years or months ago did you begin to notice these changes? (Please specify months or years)________________________

Did these changes occur ***abruptly/quickly*** (such as due to a stroke, mini stroke or head injury, etc.)? (YES/NO)
Did these changes occur ***gradually***? (YES/NO)
Do you feel like the changes in your thinking skills over time have ***Worsened since they began/Stayed the same/Improved***? (Circle one)
Has anyone in your immediate family been diagnosed with any kind of dementia including Alzheimer's Disease (YES/NO) including mother, father, brother, sister, grandmother, grandfather, uncle, and/or aunt? (Circle all that apply).

Circle all that apply to your health history:

ADD/ADHD	Encephalitis	Mini Stroke/TIA
Balance Disturbance	Exposure to blasts/IED's	Multiple Sclerosis
Brain Aneurysm	Exposure to heavy metal	Parkinson's Disease
Brain Surgery	Fainting/Syncope	Seizures/Epilepsy
Brain Shunt	Frequent Falls	Sleep Apnea
Brain Tumor/Brain Abscess	Frontal Temporal Dementia	Stroke/CVA
Breast Cancer	General anesthesia (surgery)	Tension Headaches
Chemotherapy/Radiation	Head Injury/Concussion	Transient Global Amnesia
Chronic Pain	Hepatitis	Tremors
Coma	HIV/AIDS	Urinary Incontinence
Dementia/Alzheimer's	Hydrocephalus	Valley Fever/Lyme's Disease
Dizziness	Lewy Body Dementia	Vascular Dementia
Double Vision	Meningitis	Vitamin B12 Deficiency
Dyslexia	Migraine	Vitamin D Deficiency

Have you ever had a neuropsychological evaluation before? (YES/NO)

MENTAL HEALTH HISTORY

Circle all that apply:

Alcoholism	Hallucinations (auditory/visual)	Personality or behavioral changes
Anxiety	Homicidal Thoughts	Post-Traumatic Stress Disorder
Bipolar Disorder	Obsessive-Compulsive Disorder	Prescription Abuse
Delusions	Panic Attacks	Schizophrenia
Depression	Paranoia	Substance Abuse
Fear of Social Situations	Personality Disorder	Suicidal Thoughts

Other:____

____

Do you currently have a psychiatrist? (YES/NO)
Do you currently have a counselor/psychologist? (YES/NO)
Do you take an antidepressant or medication to manage anxiety? (YES/NO)
Do you take medication for hallucinations or delusions? (YES/NO)
Have you ever been to the ER or been hospitalized due to psychological distress (depression or suicidal thoughts/attempts, anxiety attacks, etc.)? (YES/NO)
If so, what year did this occur, and which facility/hospital were you in?____________________

____

Have any of your children been diagnosed with a psychiatric condition? (YES/NO)

Do you have insomnia? (YES/NO) If so, how much do you typically sleep a night?____________
Do you have problems with falling asleep, staying asleep or both?_______________________
How much did you sleep last night?____
Do you act out in your sleep (kicking, screaming, punching, shouting, and/or reenact your dreams)? (YES/NO)

How much alcohol do you consume in an average week?________________________________
Have you ever been treated for alcoholism? (YES/NO) If so, was it inpatient or outpatient treatment?____
Do you get regular exercise? (YES/NO) If so, explain___________________________________
Do you regularly socialize? (YES/NO) or do you tend to stay home more? (YES/NO)

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Circle ***(ONE)*** number below in each section that best indicates your ability if you had to perform the task alone using your ***thinking skills (do not take into consideration physical limitations).*** If you had to perform the skill below, which number best describes your ability?

Section 1. Ability to Use Telephone Section

1 Operates telephone on own initiative, looks up and dials numbers
2 Dials a few well-known numbers
3 Answers telephone, but does not dial out
4 Does not use telephone at all

Section 2. Shopping Section

1. Takes care of all shopping needs independently
2. Shops independently for small purchases
3. Needs to be accompanied on any shopping trip
4. Completely unable to shop

Section 3. Food Preparation Section

1. Plans, prepares, and serves adequate meals independently
2. Prepares adequate meals if supplied with ingredients
3. Heats and serves prepared meals or prepares meals but does not maintain adequate diet
4. Needs to have meals prepared and served

Section 4. Housekeeping Section

1. Maintains house alone with occasional assistance (heavy work)
2. Performs light daily tasks such as dishwashing, bed making etc.
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness
4. Needs help with all home maintenance tasks
5. Does not participate in any housekeeping tasks

Section 5. Laundry Section

1. Does personal laundry completely
2. Launders small items, rinses socks, stockings, etc.
3. All laundry must be done by others

Section 6. Mode of Transportation Section

1. Travels independently on public transportation or drives own car
2. Arranges own travel via taxi but does not otherwise use public transportation
3. Travel on public transportation when assisted or accompanied by others
4. Travel limited to taxi, Uber, or automobile with assistance of another
5. Does not travel at all

Section 7. Responsibility for Own Medications Section

1. Is responsible or taking medications in correct dosages at correct time
2. Takes responsibility if medication is prepared in advance in separate dosages
3. Is not capable of dispensing own medication

Section 8. Ability to Handle Finances Section

1. Manages financial matters independently (budgets, writes checks, pays rent and bills, goes to bank) collects and keeps track of income
2. Manages day to day purchases but needs help with banking, major purchases etc.
3. Incapable of handling money

EPWORTH SLEEPINESS SCALE FORM

Instructions: Be as truthful as possible. Read the situation in the first column; select your response from the second column; enter that number in the third column.

Situation	Responses	Score
Sitting and Reading	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Watching Television	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting inactive in a public place, for example, a theater or a meeting	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
As a passenger in a car for an hour without a break	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Lying down to rest in the afternoon	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting and talking to someone	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting quietly after lunch when you've had no alcohol	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
In a car while stopped in traffic	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	