PEACHTREE NEUROPSYCHOLOGICAL ASSOCIATES, P.C.

Thomas G. Burns, Psy. D., ABPP Board Certified in Clinical & Neuropsychology

# CONFIDENTIAL ADULT PATIENT QUESTIONNAIRE

The Information requested on this questionnaire will be helpful to us in providing services to you. Please feel free to add as much information as you think will be helpful. You may use the back of the pages if it is necessary. If a question is not pertinent to you, please write N/A (Not Applicable). The highest standards of professional confidentiality are maintained.

Name: _____ Date of Birth: __ / __ / __ Age: _____
Occupation: _____ Today's Date: __ / __ / __ Injury:_____
Education: _____ Dates of Eval: __ / __ / __ DOI: __/__/__

Referred by: _____
Reason for Neuropsychological Testing: _____
_____
_____

Your Name _____ Relationship to Patient _____

What are your concerns now about your family and your family's present needs: _____
_____

**PREGNANCY AND NEWBORN HISTORY:**

Are you aware of any problems when you were born? _____
Special Procedures Used After Birth _____
Special Care Nursery _____ Length of Stay _____
Any Need for Re-Hospitalization _____
Other Problems _____
(please circle) colic sleeping problems rocking irritability feeding problems
excessive crying seizures head banging fevers ear infections

**CHILD DEVELOPMENT:**

Are you aware of any delays in development as a child (i.e. crawling, walking, talking)
_____

Any Preschool Speech Problems _____ _____
Any Problems with Learning _____ _____
Any Previous Evaluations _____ _____
Services Provided _____ _____

**MEDICAL HISTORY:**

Any serious falls or injuries _____
Any head injuries, seizures, or head trauma _____
Any serious or chronic illnesses during childhood _____
Any hospitalizations, operations, and/or surgeries _____

Physician__ _____ Practice _____
Are you on any medications? _____

Any other medical problems or concerns about your health? _____
_____

Childhood Illnesses: _____
(please circle) meningitis encephalitis otitis media nausea dizziness nervousness
visual problems stomach aches physical weakness recurrent headaches

Have you or any family member ever had one of the following evaluations? In the space provided, please indicate the reason for the evaluation and results:

| | Myself | Family Member |
|---|---|---|
| Psychological Testing | _____ | _____ |
| Psychiatric Assessment | _____ | _____ |
| Neurological Evaluation | _____ | _____ |
| Electroencephalogram (EEG) | _____ | _____ |
| CT Scan / MRI of the Brain | _____ | _____ |
| Psychotherapy / Counseling | _____ | _____ |
| Support Group (AA, NA, ACOA) | _____ | _____ |
| Alcohol / Addiction | _____ | _____ |
| Occupational Therapy | _____ | _____ |
| Speech / Language Therapy | _____ | _____ |
| Physical Therapy | _____ | _____ |
| Hearing / Vision Evaluation | _____ | _____ |
| Legal Trouble | _____ | _____ |

**ACADEMIC HISTORY:**

Most Recent School _____ Degree _____
Previous School_____ Degree _____
High School Grade Point Average _____ SAT Scores_____ (Verbal) _____
(Math)_____

Did you receive any special services or academic placement at School (explain):
_____
_____
_____

**VOCATIONAL HISTORY:**

Occupation:_____ Position: _____
Name & Address of Employer: _____
How long employed: _____

Occupation:_____ Position: _____
Name & Address of Employer: _____
How long employed: _____

Occupation:_____ Position: _____
Name & Address of Employer: _____
How long employed: _____

**SOCIAL HISTORY:**

Are you: ___ Married ___ Separated ___ Divorced ___ Single ___ Widowed

Your Name _____ Employer:_____
Position _____
Address: _____ Home Phone ( ) _____ - _____
_____ Work Phone ( ) _____ - _____
_____ Other Phone ( ) _____ - _____

Spouse's Name _____ Employer _____
Position: _____
Address: _____ Home Phone ( ) _____ - _____
_____ Work Phone ( ) _____ - _____
_____ Other Phone ( ) _____ - _____

Responsible Party _____
Children _____ Age _____ Grade _____
_____ Age _____ Grade _____
_____ Age _____ Grade _____
_____ Age _____ Grade _____

Significant marital conflict _____
Significant conflict with child _____
Unusual behaviors _____ Types of Problems _____
Social relationships _____
Organizations and Interests _____

Dominant Hand _____ Ethnicity _____ Gender M F

Person to contact in case of emergency _____
Phone ( ) _____ - _____ Relationship to patient _____

## AUTHORIZATION FOR RELEASE OF MEDICAL, EDUCATION, AND/OR PSYCHOLOGICAL INFORMATION

Please list the name, address, and/or phone number of the individuals to where you would like copies of the final Neuropsychological Report sent. The release of information provided below will serve as your permission to send the report and consult with the individuals that are listed:

I, _____ representing _____ ___/____/___, authorize
(Patient or Personal Representative) (Patient) (Patient's Date of Birth)

Dr. Thomas G. Burns and Peachtree Neuropsychological Associates, P.C. to release and obtain information from the following individuals:

Name: _____ Address: _____
_____
Telephone: _____

Name: _____ Address: _____
_____
Telephone: _____

Name: _____ Address: _____
_____
Telephone: _____

Name: _____ Address: _____
_____
Telephone: _____

The purpose for this disclosure is for Neuropsychological Assessment and Follow-up.

I have read, or had read to me, the above statements, and understand them as they apply to me. I further understand that I may revoke this consent at any time, except to the extent that action has already been taken in accord with this consent. In any event, this consent will expire (unless expressly revoked earlier) thirty-six (36) months from the date signed by the patient or legally authorize agent. Additionally, I have been given the opportunity to review the Patient Privacy Notice required by HIPAA and may request a copy if I so desire.

_____ ____ / ____ / ____
(Signature of Patient or Personal Representative ) (Date)

_____
(Description of Personal Representative's Authority)

_____ ____ / ____ / ____
(Witness) (Date)

**** Note: Please provide copies of any previous assessments, medical reports, and/or academic records that would be helpful in completing your evaluation.

Thank you for your cooperation,
Dr. Burns