Adult - Assessment Forms

Please complete these forms prior to first assessment appointment.

Patient Registration Information

Patient's Name

First | Middle | Last

Patient's Gender

○ Man ○ Woman

⊙

Patient's Date of Birth

Home Phone

Cell/Work Phone

May we leave a message on your Home Phone?

○ Yes ○ No

May we leave a message on your Cell Phone?

○ Yes ○ No

Address

Address Line 1

Address Line 2

City | State | Zip Code

Parent/Guardian's Name (If Applicable)

First | Middle | Last

Parent/Guardian's Cell/Work Phone (If Applicable)

Parent/Guardian's Email (If Applicable)

In Case of Emergency, Please Contact:

First

Last

Emergency Contact's Relationship to Patient

Emergency Contact Phone Number

Chose Clinic Because/Referred to Clinic by (Please choose one)

○ Doctor ○ Insurance Plan ○ Hospital ○ Family/Friend ○ Convenient Location ○ Found on Google or Social Media

⊙

Payment (Choose One)

○ I will pay for these services directly and do not wish to have you bill my insurance.

○ Please bill my insurance using the information provided on the next page.

Insurance Information

Primary Insurance Name:

E.g. BCBS, Aetna, etc

Subscriber (Policy holder)'s Social Security Number

Policy holder's SSN

Subscriber (Policy holder)'s Date of Birth

Patient's Relationship to Subscriber

○ Self ○ Spouse ○ Child

⊙

Name of Subscriber

First

Last

ID or Policy Number

Group Number

Occupation of Subscriber

Subscriber's Employer

Employer's Address

Address Line 1

Address Line 2

City | State | Zip Code

Employer's Phone

Secondary Insurance Name

Name of Insured

First

Last

Patient's Relationship to Subscriber

○ Self ○ Spouse ○ Child

⊙

ID or Policy Number

Group Number

(Initials) I authorize Mission Psychology and the above insurance provider(s) to release any information required to process my claims.

Cancellation Policy

Failure to cancel an appointment within 24 hours of the scheduled time is considered a "No-Show" and is billed at the full rate. I understand that insurance usually does to pay for no-shows, and I will be responsible for the fee myself.

Initials

Authorization of Treatment and Payment

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Mission Psychology. I understand that I am financially responsible for any balance.

Signature

Date

Name of Responsible Party

First

Last

Notice of Receipt of Policy Regarding Protected Health Information

Please sign below to indicate that you have been given the opportunity to review Mission Psychology's policies regarding protected health information. If you request it, we will provide you with a paper copy of the policy.

Name

First

Last

Signature

Date

Credit Card Authorization

We require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable, including, but not limited to, copayments, coinsurance, any amount applied to your deductible, no show appointment fees, and other billing charges. If you have any questions or concerns about this policy, please discuss with your clinician before signing.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to your account.

I authorize Mission Psychology to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Card Type
⊙ Visa ○ Mastercard ○ Discover

Credit Card Number

Expiration Date

3-Digit Security Code

Cardholder Name

First

Last

Signature

Billing Address

Address Line 1

Address Line 2

City

State

Zip Code

I, the undersigned, authorize and request Mission Psychology to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Mission Psychology. This authorization will remain in effect until I cancel this authorization. To cancel, I must give 60 day notification to Mission Psychology in writing and the account must be in good standing.

Patient Name

First

Last

Responsible Party Name

First

Last

Responsible Party Signature

Date

Adult Neuropsychology Questionnaire

The following is a questionnaire about your development, medical history, and current functioning at home and at work. This information will be integrated with any testing results or case conceptualization to provide a better picture of your abilities as well as any problem areas. Please fill out this questionnaire as completely as you can.

Name

First | Last

Birthdate | **Current Age**

Name of Person Completing Form | **Relationship to Patient**

First | Last

What questions do you hope will be answered?

What Concerns Bring you Here?

Social History

Birth Country | **Age upon Arrival in Country if Born Elsewhere**

Where were you raised? | **Who raised you?**

How many brothers and sisters did you have?

Marital Status of Biological Parents

○ Married ○ Separated ○ Divorced ○ Widowed

⊙

Your Current Marital Status | **Number of Times Married**

○ NM/Single ○ Married ○ Divorced ○ Widowed

⊙

Do you have any children?
○ Yes ○ No

Primary Language Spoken in Home
○ English ○ Spanish
⊙

Other Languages Spoken in the Home

Education Program

Did you ever fail or repeat a grade?
○ Yes ○ No

Were you in any special education classes?
○ Yes ○ No

Did you have a Learning Disability?
○ Yes ○ No

Were you ever called "Hyperactive?"
○ Yes ○ No

Were you diagnosed with an attention deficit (i.e. ADD/ADHD)?
○ Yes ○ No

Did you take Ritalin or other stimulant medications to help you in school?
○ Yes ○ No

List other medications taken during childhood:

Check the following if they applied to you in school
☐ Could not sit still
☐ Always "on the go"
☐ Needed a lot of supervision
☐ Could not organize/finish work
☐ "Fidgety" and restless
☐ Acted before thinking

☐ Could not stay seated
☐ Got in a lot of trouble
☐ Speaking out of turn
☐ Was a bully
☐ A "slow learner"
☐ Had trouble paying attention
☐ Destroying property
☐ Fighting
☐ Used drugs or alcohol
☐ Counseled a lot by principals, teachers, etc.

Describe any other problems you had during school:

Were you on the Honor Roll or Dean's List?
○ Never ○ Rarely ○ Usually ○ Always

Did you graduate high school?
○ Yes ○ No

Typical grades?

Did you attend college?
○ Yes ○ No

What are your future educational plans?

Occupational History

Are you currently employed?
○ Yes ○ No

What jobs have you held in the past?

What has been your main type of work through the years?

List any problems in your current or past work:

Have you served in the military?
○ Yes ○ No

What are your future occupational plans?

Developmental History

Were there any complications or problems with your mother's pregnancy and delivery?
○ Yes ○ No

Were you born full term?
○ Yes ○ No

What was your birth weight?

Check any that apply to the birth:
☐ Labor Induced ☐ Assisted Delivery (Forceps, vacuum) ☐ Breech ☐ C-Section ☐ Unknown

At what age did you walk?

At what age did you talk?

Medical History

Vision Problems?
○ Yes ○ No

Date of last vision exam

Hearing Problems?
○ Yes ○ No

Date of last hearing exam

Have you ever had a significant head injury?
○ Yes ○ No

Please check any of the following that you have ever had:

☐ Coma
☐ Diabetes
☐ Hypoglycemia
☐ Seizures
☐ Meningitis
☐ Stroke
☐ Sun Stroke
☐ Dementia
☐ Kidney Disease
☐ Liver Disease
☐ Encephalitis
☐ Arteriosclerosis
☐ Venereal Disease
☐ Heart Disease
☐ Delirium
☐ Infections
☐ Multiple Sclerosis
☐ Hypertension
☐ Tumor/Cancer
☐ Brain Abscess (aneurysm)
☐ Thyroid Problems
☐ Amnesia/Memory Loss
☐

Please check any of the following that you have ever experienced or been exposed to:

☐ Lead (in paint, etc)
☐ Partial Drowning
☐ Overcome by Gas
☐ Lack of Oxygen
☐ Carbon Monoxide
☐ Toxic Chemicals
☐ Electrical Shock
☐ Industrial Solvents
☐ Malnutrition
☐ Chemical Accidents
☐

FAMILY MEDICAL HISTORY - Indicate any problems that any family member has had:

☐ Seizures/Epilepsy
☐ Intellectual Disability
☐ Depression or Anxiety
☐ Alcohol or Drug Abuse
☐ Sexual Abuse
☐ Antisocial Behavior
☐ Attention Deficit
☐ Behavior Problems
☐ Neurological Disease
☐ Suicide Attempt
☐ Parkinson's Disease
☐ Learning Disabilities
☐ Mental Illness
☐ Tics or Tourette's Syndrome
☐ Physical Abuse
☐ Huntington's Disease
☐

List any previous assessments you have had:

Psychiatric (Include Date of Testing and Name of Examiner)

Neuropsychological (Include Date of Testing and Name of Examiner)

Educational (Include Date of Testing and Name of Examiner)

Speech Pathology (Include Date of Testing and Name of Examiner)

If possible, please upload any previous assessment results/reports here:

List any form of Mental Health Treatment the you have had (e.g., psychotherapy, family therapy, residential treatment).

Have you ever attempted suicide?
☐ Yes ☐ No

Please check any of the following that you have experienced recently in the last few months/years:

☐ Impulsivity (act before thinking)
☐ Periods of Confusion
☐ Nausea or Vomiting
☐ Memory Problems
☐ Shaking or Tremor
☐ Change in Smell or Taste
☐ Loss of Interest
☐ Shaking or tremor
☐ Problems with Judgment
☐ Difficulty doing things you used to do well
☐ Blank Spells
☐ Getting Lost
☐ Severe Headaches
☐ Temper outbursts
☐ More Easily Frustrated
☐ Personality Changes
☐ Walking Differently
☐ Inability to pay attention
☐ Hallucinations
☐ Dizziness
☐ Ringing in Ears
☐ Visual Changes

☐ Fainting
☐ Hearing Changes
☐ Loss of bladder or bowel control
☐ Numbness in the body
☐ Uncontrollable Laughing or Crying
☐ Unusual Weakness
☐ Loss of coordination
☐ Loss of ability to have sex
☐ Burning/Tingling in the Body
☐

Please explain the items checked above

Do you have arthritis/injuries in your shoulders, arms, or hands that would affect your feeling, strength, or speed in your limbs?
☐ Yes ☐ No

Current Medications

Are you currently taking any medications?
○ Yes ○ No

Substance Use

Do you drink alcohol?
○ Yes ○ No

Were you a heavy drinker in the past?
○ Yes ○ No

How much coffee do you drink?

Please list any other non-prescribed chemicals or drugs that you have abused now or in the past:

Have you ever participated in any substance abuse treatment program?

○ Yes ○ No

Other Concerns

Do you have an application for disability pending with the:
☐ VA ☐ Social Security ☐ N/A
☐

What disability are you claiming?

Is there anything about your current functioning or about your past experiences that you think would be helpful for us: