Alan J. Drucker, M.D., Inc.

2150 E. Tahquitz Canyon Way, Suite 6
Palm Springs, CA 92262
*(760) 322-3705 * FAX (888) 392-6660*

alan.drucker@verizon.net

Adult Psychiatry

GENERAL INFORMATION

1. **THESE FORMS MUST BE COMPLETED AND RETURNED TO THE OFFICE AT LEAST 1 WEEK PRIOR TO YOU INITIAL APPOINTMENT. PATIENTS WILL NOT BE SEEN IF THESE FORMS HAVE NOT BEEN COMPLETED AND RETURNED BY 1 WEEK PRIOR TO THE INITIAL EVALUATION.**

2. We make every effort to verify your insurance benefits prior to your initial appointment, and to ensure that Dr. Drucker is a provider for your insurance. However, at times this is not possible or the information we receive is not accurate. We recommend that you also contact your insurance to verify your coverage and to ensure that Dr. Drucker is a provider for your particular insurance plan.

3. Please arrive 10 minutes prior to the first appointment. Please have your current insurance card with you. Please also bring ALL of your current medications with you to your appointment.

4. It is our office policy that you provide us with payment in full at the time of service for any Co-Payment due for your visit. Please be prepared to make payment at the time of service. Payment may be made by Cash, Check, or Credit/Debit Cards (VISA, MasterCard, American Express, and Discover Card are accepted).

5. If you have any questions, please feel free to contact our office at (760) 322-2705 of by email at PalmSpringsPsych@verizon.net

NOTICE TO PATIENTS OPEN PAYMENTS DATABASE

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospital be made available to the public.

You may search this federal database for payments made to physicians and teaching hospitals by visiting this website:

https://openpaymentsdata.cms.gov/

Patient Signature: _____

Patient Name: _____

Date: ____/____/_____

PATIENT AND BILLING DATA

PATIENT

Name: Last First MI Sex: ☐ M ☐ F

Address: City: State: Zip Code:

Home Phone: Cell Phone: Work Phone: Ext.:

Your Title: (Please check one) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other: Date of Birth: / /

What is your relationship to the Responsible Party?

☐ Self ☐ Spouse ☐ Daughter ☐ Son ☐ Other (specify):

Who referred you to this office?

Occupation: Employer:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Social Security #: / / Driver's License#:

If patient is a minor, he/she resides with:

☐ Mother ☐ Father ☐ Both Parents ☐ Other (please specify):

Email Address:

ACCOUNT RESPONSIBLE (Person who will pay the balance after insurance pays)

☐ Self ☐ Spouse ☐ Parent ☐ Other (please specify):

Name: Last First MI

Address: City: State: Zip Code:

Home Phone: Cell Phone: Work Phone: Ext.

Primary Care Physician: Phone:

In case of emergency, contact:

Their relationship to you:

Their home phone: Cell Phone: Work Phone:

Is your condition work related? ☐ Yes ☐ No

If referred by Attorney or litigation is pending:

Name of Attorney:

Address: City: State: Zip

Phone:

PRIMARY INSURANCE COMPANY

Name:

Mailing Address (for mental health claims):

City: State: Zip Code:

Attention: Phone:

INSURED (The person who is the policy holder)

Name: Last First MI

Address:

City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

Patient's relationship to insured?

☐ Self ☐ Spouse ☐ Daughter ☐ Son ☐Other (specify):

Insured Date of Birth: / / Sex: ☐ M ☐ F

Employer:

ID#: Effective date of insurance: / /

Group Claim #: Group Name:

SECONDARY INSURANCE COMPANY

Name:

Mailing Address (for mental health claims):

City: State: Zip Code:

Attention: Phone:

INSURED (The person who is the policy holder)

Name: Last First MI

Address:

City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

Patient's relationship to insured?

☐ Self ☐ Spouse ☐ Daughter ☐ Son ☐Other (specify):

Insured Date of Birth: / / Sex: ☐ M ☐ F

Employer:

ID#: Effective date of insurance: / /

Group Claim #: Group Name:

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OFFICE POLICIES AND GENERAL INFORMATION

Dr. Drucker would like to welcome you to his practice and is pleased to have you as a patient. We are providing you with this informational letter to help you understand how the office operates. Every effort will be made to treat you with courtesy and respect. Should you have any questions or need more information, do not hesitate to ask.

APPOINTMENTS:

Patients are seen only by appointment. Before your first visit with Dr. Drucker, please complete **ALL** of these forms, and be sure to return them to the office at least 1 week prior to your appointment. **YOU WILL NOT BE SEEN BY THE DOCTOR UNLESS ALL FORMS ARE FILLED OUT PRIOR TO YOUR VISIT.** If these forms cannot be filled out prior to your appointment, then please arrive one hour early in order to complete these forms. If you have already completed these forms, then please arrive at least 15 minutes prior to your first appointment time to allow the office staff to prepare your chart and have you complete any last minute forms.

Upon arrival at the office, please check with the receptionist so that your chart may be completed and Dr. Drucker can be notified of your presence. You will need to bring the completed forms, your insurance card(s), and any medications you are currently taking to your first appointment. If this appointment is for a minor or a dependent adult, then the parent or guardian must also attend the first visit and provide authorization for treatment.

Initial visits will usually last 45 to 50 minutes. Medication management visits may last between 15 and 30 minutes. Individual psychotherapy visits may last either 20 minutes or 45 minutes. The type of follow-up appointment indicated for you will be discussed during your initial evaluation by Dr. Drucker.

CANCELLATIONS:

When you schedule an appointment, that time is reserved specifically for you. Appointment reminder cards are provided whenever subsequent appointments are scheduled at the office. **It is the patient's responsibility to remember and keep scheduled appointments**. **A minimum of 24 hours notice** is required if you are canceling or rescheduling an appointment. Missed appointments and appointments which are canceled with less than 24 hours notice will incur a $60 fee which is the patient's financial responsibility. Most insurance companies do not reimburse for missed appointments. (PATIENT INITIAL: _____)

Patients who arrive late for their appointment may be seen for the time which remains of the scheduled session at the discretion of Dr. Drucker. The session will not be extended past the allotted time. Patients arriving late will still be charged for the full session.

EMERGENCIES:

Dr. Drucker may be reached by calling the office phone number 24 hours a day in the event of an emergency. In the event that Dr. Drucker is unavailable due to illness, vacation, or other circumstances, the office staff and the answering service will forward emergency calls to the physician who has agreed to handle crisis calls for him. In the event that Dr. Drucker or the physician accepting calls for him is unable to be reached, then patients should dial '9-1-1' to access emergency medical services, or should seek treatment at the nearest hospital Emergency Room.

CONFIDENTIALITY AND RELEASE OF INFORMATION:

Information disclosed within sessions and information which is recorded in the medical record are confidential and will not be released to others without the written consent of the patient, or of the parent/guardian in the case of minors and/or dependent adults, except in such situations as required by law. Dr. Drucker is mandated by California law in defined circumstances to report otherwise confidential information to appropriate agencies and/or authorities. Under these circumstances, a patient's right to confidentiality is automatically waived to allow Dr. Drucker to release information to the extent necessary to comply with the law. Circumstances which are required to be reported include, but may not be limited to, the following:

1. Patients who pose an imminent threat of danger to themselves or to others
2. Instances of suspected abuse or neglect of a child (physical, sexual, and/or emotional abuse)
3. Instances of suspected abuse or neglect of a dependent adult
4. Minors who are victims of certain crimes
5. Newly made diagnoses of: Alzheimer's or other dementia; Tuberculosis (TB); Acquired Immune Deficiency Syndrome (AIDS); Syphilis, Gonorrhea, or other sexually transmitted diseases

Disclosure of confidential information may also occur pursuant to a legal proceeding. In the event that your emotional and psychological functioning is at issue in legal action initiated by you, your treatment and billing records may be subpoenaed, and Dr. Drucker may be subpoenaed to provide testimony about your treatment.

Disclosure of confidential information might be required by your insurance company(s) or by Workers Compensation insurance company, or by an HMO/PPO/MCO/EAP in order to process your insurance claim and/or to obtain authorization for treatment. In these instances, only the minimum necessary information will be communicated to the insurance carrier. Dr. Drucker has no control over how the insurance company(s) utilize this information, or the re-release of this information by the insurance company(s). Dr. Drucker assumes no responsibility for any actions which result from a third party misusing or re-releasing such information without his expressed consent.

All patients have the right to review or to receive a summary of their medical records at any time, except in limited legal circumstances, or in circumstances where Dr. Drucker concludes that the release of such information would in any way be harmful to the patient. In such situations, arrangements may be made to provide the medical records or a summary of the medical records to another qualified mental health professional mutually agreed to by the patient and Dr. Drucker. That individual may then choose to review the information with the patient if it is deemed clinically appropriate. Medical records will generally be made available within five (5) working days of receipt of a valid written request.

All other requests to release information regarding your treatment and your condition must be authorized in writing specifically allowing the release of psychiatric records. Dr. Drucker will provide you with a Release of Information form, or you may place your request in writing. There will be no charge for releasing medical records requested by other treating medical or mental health professionals. For all other requests to copy medical records there will be a minimum charge of $20 dollars to cover the expenses of photocopying, postage, and handling.

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PATIENT CONSENT
NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting the Office Manager at (760) 322-3705.

You have the right to request that we restrict how Protected Health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to these restrictions, but if we do, then we shall honor those agreements.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosure(s) which was/were already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing this form, you understand that:

- Protected Health Information may be disclosed or used for treatment, payment, or health care operations (including coordination of care with other physicians, hospitals, laboratories, pharmacies, etc.);
- the Practice has a Notice of Privacy Practices and that you have been given the opportunity to review this Notice;
- the Practice reserves the right to change the Notice of Privacy Practices;
- the Patient has the right to request restrictions regarding the uses of their information, but the Practice does not have to agree to those restrictions;
- the Patient may revoke this Consent in writing at any time, and all future disclosures of PHI will then cease;
- the Practice may condition treatment upon the execution of this Consent.

Patient or Representative's Signature

Relationship (if other than Patient)

Patient Name (Printed)

Date

FINANCIAL AGREEMENT & OFFICE BILLING /INSURANCE POLICIES

1. I understand that professional services are rendered and charged to the patient and not to the insurance company. Not all issues/conditions/problems which are the focus of psychotherapy or an evaluation are reimbursed by insurance companies. **It is my responsibility to verify the specifics of my coverage. I am responsible for payment for any services or charges not covered by my insurance.** I understand that this office does not assume responsibility for claim denials, claim disputes, or for insurance payment of my account.

2. I agree to pay all deductibles, co-payments, and/or co-insurance amounts not paid by my insurance(s). These will be paid at the time services are rendered, unless other arrangements have been made. Under no circumstances does this office accept liens as payment on an account.

3. I understand that if my insurance(s) require a referral from my primary care physician, Dr. Drucker must have verification of the referral **prior** to my first appointment. I will bring my insurance information or insurance card(s) to my first appointment so that the office can properly identify my program(s).

4. If my sessions are to be billed to **Worker's Compensation**, I will provide the name of my carrier, the address where the billing is to be sent, my claim/case number, the name and phone number of my case worker, and a copy of the "Employee's Claim for Worker's Compensation Benefits" (DWC Form 1).

5. I authorize the release of information concerning my treatment or the treatment of my dependent(s) to my insurance company(s), including that an insurance company representative may review the clinical record.

6. I authorize direct payment by my insurance company(s) to Alan J. Drucker, M.D., Inc.

7. I accept ultimate responsibility for payment for the services that I or my dependent(s) receive, whether or not my insurance(s) cover these services. This includes, but is not limited to fees for: clinical services or treatment, failed appointments and/or appointments not cancelled with 24 hours notice, report/letter writing, time spent in court or talking to attorneys on my behalf or the behalf of my dependent(s), telephone conversations longer than 5 minutes, site visits, reading records, longer sessions, travel time, etc.

8. I understand that I will receive a statement if I have an outstanding balance on my account and I am to pay any portion that is my responsibility within 15 days of receipt of a statement. A finance charge of 1% per month may be added to my account if payment is overdue.

9. I understand that there will be a $20.00 service fee for any checks returned by my bank due to non-sufficient funds, closed accounts, etc. I agree to accept full responsibility for such fees. The amount of the returned check, plus the service fee, must be paid within 10 days of written notice.

10. I will notify the Office Manager if any problem arises regarding my ability to make timely payments. If my account is overdue (unpaid) and there is no agreement on a payment plan, I understand that this office can use legal means (court, collection agency, etc.) to obtain payment.

11. I am aware of Dr. Drucker's office policy requiring 24 hours notice to cancel an appointment. I understand that I may notify the office staff or the answering service of my intention to cancel an appointment. I further acknowledge that I will be charged **$60.00** for any appointment which I or my dependent(s) fail to keep without providing 24 hours notice.

My signature below signifies that I have read, understood, and agree to the above terms of the office policies, this financial agreement and office billing/insurance policies.

Patient Name (Printed)

Responsible Party (Printed) (If patient is a minor or dependent adult)

Signature of Responsible Party

Date

RELEASE OF INFORMATION:

I hereby provide authorization for Alan J. Drucker, M.D. to contact my PHYSICIAN, _____ and exchange information regarding my medical, psychiatric, and any alcohol/substance abuse condition and treatment.

I hereby provide authorization for Alan J. Drucker, M.D. to contact my THERAPIST, _____ and exchange information regarding my medical, psychiatric, and any alcohol/substance abuse conditions and treatment.

Signature: _____ Date: _____

CONSENT FOR TREATMENT:

I hereby provide consent for Alan J. Drucker, M.D. to provide medical psychiatric services to me, including a diagnostic psychiatric evaluation and such treatment as is medically indicated for any psychiatric diagnosis identified. Treatment may consist of prescribing medications, psychotherapy, or referral(s) to other therapists, medical providers, and/or support groups as appropriate. Dr. Drucker will discuss with me his treatment recommendations, and I understand that I will be asked to make an informed decision to accept or to refuse the recommended treatment. I acknowledge that the treatment being offered to me is expected to relieve symptoms of psychological distress, but that no guarantee is provided that treatment will result in the desired outcome. I further acknowledge that treatment sometimes will temporarily intensify psychological distress, and that this is a normal reaction to discussing emotionally painful subjects and life experiences or may be an adverse effect of psychiatric medication(s).

Signature: _____ Date: _____

MANDATED REPORTING OF CONDITIONS:

I have been informed that Alan J. Drucker, M.D. is mandated by California law in defined circumstances to report otherwise confidential information to appropriate agencies and/or authorities, and that under such circumstances my rights to confidentiality are automatically waived to the extent required for Dr. Drucker to comply with the law. I understand that circumstances which are required to be reported include, but may not be limited to, the following:

1. A patient poses an imminent threat of danger to him/herself or to others.
2. Instances of suspected child abuse (physical, sexual, emotional) or child neglect.
3. Instances of suspected abuse or neglect of a dependent adult.
4. Individuals who are the victim of certain crimes.
5. New diagnoses of: Alzheimer's Disease or other dementia; Tuberculosis (TB); Acquired Immune Deficiency Syndrome (AIDS); Syphilis, Gonorrhea, or other sexually transmitted diseases.

Signature: _____ Date: _____

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PAYMENT AGREEMENT/AUTHORIZATION TO BILL INSURANCE

Name of Patient: _____
Please print name

Our office policy states that if Dr. Drucker is not a participating, contracted provider with your health plan, then payment in full is due at the time of service.

Please read the following declaration then sign and date below where indicated.

> I request that payment of authorize medical services furnished to me or my minor child be made by my insurance company, on mine or my minor child's behalf, to the provider of service indicated above. I authorize the medical provider listed above and his agents to release any information concerning my medical care to my insurance company and any of its agents for the sole purpose of determining benefits payable on my medical related charges.
>
> I understand my signature on this form authorizes my insurance company to make payment directly to the provider referenced above and that I am authorizing my provider to release all medical information necessary to adjudicate my medical claims. If other health insurance coverage is indicated in Item 9 of the Expo-1500 claim form, or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes release of my medical information to that insurance company or agency as well. In HMO, PPO, or IPA assigned insurance, where the physician or supplier referenced above is a participating provider, my provider agrees to accept the allowable charge determination of my insurance carrier as the full charge, and the patient is responsible only for deductibles, coinsurance, in any non-covert services. Deductibles and coinsurance are based upon the charge to termination of my insurance carrier. If the provider is not a participating provider, then I, as the patient or responsible party understand the charges in full or my responsibility AND ARE PAYABLE AT THE TIME OF EACH SERVICE.

I understand that if Dr. Drucker is not a participating provider, I will pay for services in full at the time of service. This policy applies to secondary and subsequent plans as well.

***I understand this to be a lifetime beneficiary insurance authorization, unless I cancel this authorization and writing.

_____ _____
Signature of Insured or Responsible Party Date

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Adult Psychiatry

NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

Dignity and Respect

- You have the ***right*** to be treated with consideration, dignity and respect.
- You have the ***responsibility*** to respect the rights, property and environment of all physicians, health care professionals, employees, and other patients at this office.
- you have the ***right*** to access your own treatment records and have the privacy and confidentiality of those records maintained
- you are entitled to these rights regardless of gender, age, sexual orientation, marital status, culture, economic, educational, or religious background.

Knowledge and Information

- you have the ***right*** to receive information about the office's services and practitioners, clinical guidelines, and members' rights and responsibilities
- you have the ***right*** and you have the ***responsibility*** to know about and understand your health care and your coverage, including:
  - Participating with your physician and other healthcare providers in decision making regarding your treatment planning. Having participated and agreed to a treatment plan, you have the ***responsibility*** to follow the treatment plan and/or advise your physician/healthcare provider otherwise.
  - The names and titles of all health care providers involved in your treatment.
  - Your clinical condition and health status.
  - Any services and procedures involved in your recommended course of treatment.
  - Any continuing health care requirements following discharge from your provider's office, hospital, or treatment program.
  - How your health plan operates as stated in your Policy and/or Certificate

Continuous Improvement

- As a partner with your health plan and any healthcare professional involved in your care, you have the ***right*** to:
  - Contact a representative of your insurance plan to address all questions and concerns as well as to make suggestions for improvement of the health plan and/or members' rights and responsibilities.
  - Ask questions about any clinical advice or prescribed treatment if you need an explanation or desire more information.
  - Appeal any unfavorable behavioral health care decisions by following the established appeal or grievance procedures of your insurance plan.

Eligible Employee Accountability/Autonomy

- As a participant in your own health care, you have the ***right*** to refuse treatment and/or the ***right*** to refuse to participate in any medical research projects, providing you accept responsibility for the consequences of such a decision.
- You have a ***responsibility*** to participate, to the degree possible, in understanding your behavioral health problems and developing mutually agreed to treatment goals.
- You have the ***responsibility*** to:
  - Inform your healthcare provider of your insurance coverage and notify him/her of any changes in your insurance coverage.
  - Provide your current healthcare provider with previous treatment records (if requested) and to provide accurate and complete medical information to all healthcare providers involved in your treatment.
  - Be on time for all appointments and to provide a minimum of 24 hours notice if you need to cancel or reschedule and appointment.
  - Receive all non-emergent or urgent care from your treating provider.
  - To obtain any necessary treatment preauthorization from your insurance carrier as required by your insurance policy.
  - To pay all required co-payments and/or insurance deductibles at the time you receive services.
- You have the ***right*** at any and all times to contact a customer service agent from your insurance carrier to obtain assistance resolving issues regarding your insurance plan.
- You have the ***right*** to have each of the above rights and responsibilities apply to a person you designate with legal authority to make decisions regarding your health care.

If you have questions or complaints regarding your rights and responsibilities, contact the Customer Service Representative for your insurance company.

Patient's Signature: _____ Date: _____

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Adult Psychological History

Date:_____

Name of person filling out form _____ Relationship to patient _____

Patient Name:_____ Sex:_____ Age:_____ Date of Birth:_____

Social Security #_____ Employer:_____

Home Address:_____

Home Phone:_____ Work Phone:_____

Referred By:_____ Reason For Referral:_____

Litigation Pending?_____ Attorney:_____ Phone:_____

History of Present Problem

How long ago did problems begin: _____

Please describe the problems that you want help with:

_____ _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Psychiatric History

Place a check to indicate if any problems apply currently (in the last six months) or in the past.

Now	Past		Now	Past	
____	____	Suicidal thoughts	____	____	Homicidal thoughts
____	____	Depression/sadness	____	____	Anxiety/nervousness
____	____	Recurrent/intrusive thoughts	____	____	Nightmares
____	____	Difficulty sleeping	____	____	Loss of appetite
____	____	Overeating	____	____	Weight loss
____	____	Weight gain	____	____	Sexual problems
____	____	Visual/auditory hallucinations	____	____	Apathy
____	____	Anorexia/Bulimia	____	____	Explosive anger
____	____	Rapid mood changes	____	____	Euphoria (feel on top of the world)
____	____	Decreased need for sleep	____	____	Racing thoughts
____	____	Easily Distracted	____	____	Feeling worthless
____	____	Fatigue	____	____	Loss of interest in almost all activities
____	____	Poor self esteem	____	____	Feelings of hopelessness
____	____	Overwhelming need to perform certain behaviors/rituals	____	____	Recurrent/intrusive disturbing recollections or dreams
____	____	Significant concerns with physical problems	____	____	Excessive fears or phobias
			____	____	Other problems: _____

Indicate which stressors you are experiencing currently (within the last 6 months) or in the past.

Now	Past		Now	Past		Now	Past	
____	____	Death of spouse	____	____	Death of family member	____	____	Illness of family member
____	____	Illness of friend	____	____	Personal injury/illness	____	____	Marital difficulties
____	____	Marital separation	____	____	Divorce	____	____	Sexual difficulties
____	____	Conflicts with family	____	____	Conflicts with friends	____	____	Conflicts at work
____	____	New job	____	____	Job termination	____	____	Retirement
____	____	Business difficulties	____	____	Academic difficulties	____	____	Financial problems
____	____	Change in residence	____	____	Legal problems	____	____	Sexual assault
____	____	Incest/sexual abuse	____	____	Physical abuse	____	____	Verbal/emotional abuse
____	____	Other problems: _____						

Are you currently receiving therapy?_____ From whom?_____
When did you start therapy?_____ For what problems(s)?_____
_____
List current psychiatric medications:_____

Have you received therapy in the past? _____ From whom? _____
When (Start and finish): _____ For what problem(s)? _____

List past psychiatric medications: _____

Have you been hospitalized for psychological problems/Substance Abuse? Yes No When? _____
Where were you hospitalized? _____
Have you ever attempted suicide? Yes No When? _____ How? _____

Check the box for any substances you currently use (Even if only occasionally or in small amounts):

☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Barbiturates ("Downers") ☐ Tranquilizers
☐ Amphetamines ("Speed") ☐ Crank ☐ Crack ☐ Cocaine ☐ Opiates (Heroine, Opium, Codeine, etc.)
☐ Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) ☐ PCP ("angel dust") ☐ Other: _____

Check the box for any substances you have taken in the past (Even if only occasionally or in small amounts):

☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Barbiturates ("Downers") ☐ Tranquilizers
☐ Amphetamines ("Speed") ☐ Crank ☐ Crack ☐ Cocaine ☐ Opiates (Heroine, Opium, Codeine, etc.)
☐ Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) ☐ PCP ("angel dust") ☐ Other: _____

Have you had a prior psychological or neuropsychological evaluation? Yes ___ No ___ If yes, complete this information:
Name of psychologist: _____
Address: _____
Phone: _____ Date of and reason for this evaluation:_____
Findings of the evaluation: _____

Birth and Developmental History

City and State of Birth: _____

Were your parents married at time you were born? □ YES □ NO

Was your mother under a doctors care during pregnancy? □ Yes □ No

Were you adopted? □ Yes □ No If so, at what age? _____

Did your mother have any of the following illnesses during pregnancy?

□ Anemia	□ Toxemia	□ Herpes	□ Measles	□ German measles	□ Bleeding
□ Kidney disease	□ Heart disease	□ Hypertension	□ Abdominal trauma	□ Infection	□ Diabetes

What medications did your mother take during pregnancy with you: _____

Did your mother drink alcohol or use recreational drugs during pregnancy? □ Yes □ No If yes, specify: _____

Did your mother have any significant emotional stresses during pregnancy? □ Yes □ No If yes, describe: _____

Was your birth: □ On time □ Premature (By how long _____) □ Late (By how long _____)
Was your birth: □ Spontaneous □ Induced □ Cesarean required?_____
Any other problems that occurred at your birth: _____
Was general anesthesia used? _____ Were forceps used? _____ Were there breathing problems? _____

Circle those that apply to the first few weeks after birth:

Excessive sleeping Laziness Irritability Excessive crying Stiffness Limpness Tremors Twitching Feeding difficulties Vomiting Jaundice
Other: _____
Transfusions required? _____ Medication required? (For what) _____ Surgery required? (For what) _____

Give approximate ages that developmental milestones were achieved (if known):

Head control_____	Rolled over _____	Sat alone_____	Walked_____	Run_____
Said first word_____	Used sentences _____	Self feeding w/ utensils_____	Toilet trained_____	
Dress self_____	Tie shoes _____	Color within lines_____		

Circle any problems that occurred in later development (Grades K-6):

Hearing Speaking Stuttering Reading Writing Spelling Arithmetic Behavior Hyperactivity Attentional difficulties Seizures Coordination

List family members with developmental or learning problems:_____

Medical History

Please check all the conditions that have been diagnosed as a child or an adult.

☐ AIDS or HIV+	☐ Diabetes	☐ Immune system disease	☐ Pancreatitis
☐ Allergies	☐ Enzyme deficiency	☐ Jaundice	☐ Parkinson's Disease
☐ Arthritis	☐ Encephalitis	☐ Kidney Stones	☐ Prostate Enlargement / BPH
☐ Asthma	☐ Fibromyalgia	☐ Liver disorder	☐ Renal Failure / Chronic Kidney Disease
☐ Autoimmune Disorder	☐ GERD / Stomach Ulcer	☐ Lung disease	☐ Senility (Dementia)
☐ Anemia	☐ Glaucoma	☐ Lead poisoning	☐ Sleep Apnea
☐ Bleeding disorder	☐ Head injury or Concussion	☐ Leukemia	☐ Stroke / CVA / TIA
☐ Blood disorder (Lymphoma)	☐ Heart Attack / Heart Problems	☐ Lupus (SLE)	☐ Tuberculosis (TB)
☐ Brain Infection or Disease	☐ Hereditary disorder	☐ Meningitis	☐ Thyroid Disease
☐ Chronic Fatigue Syndrome	☐ Headaches / Migraines	☐ Macular Degeneration	☐ Tumor
☐ COPD / Emphysema	☐ Hearing problems	☐ Malnutrition	☐ Vascular Disease / Problems
☐ Cholesterol/Triglyceride High	☐ Hepatitis	☐ Miscarriage(s)	☐ Venereal disease
☐ COVID-19	☐ High Blood Pressure / HTN	☐ Multiple sclerosis	☐ Vision problems
☐ Carbon monoxide poisoning	☐ Huntington's Disease	☐ Oxygen deprivation	☐ Vitamin B12 Deficiency
☐ Cancer	☐ Hazardous substance exposure	☐ Pain Disorder (Chronic)	☐ Vitamin D Deficiency

☐ Other medical/physical problems_____

Have you ever been diagnosed with epilepsy or a seizure disorder? ☐ Yes ☐ No If yes, check the one you have been diagnosed with:

PARTIAL	GENERALIZED	
☐ Simple partial (Jacksonian)	☐ Absence (Petit mal)	☐ UNCLASSIFIED TYPE
☐ Complex partial (Psychomotor)	☐ Myoclonic	
☐ Partial evolving into generalized	☐ Clonic	
	☐ Tonic	
	☐ Tonic-clonic (Grand mal)	
	☐ Atonic	

Medication Name, Strength, How often

List any medications currently being taken (prescription or over-the-counter), including Name, Dosage (strength) and how many times per day you take it.

1) _____ 6) _____
2) _____ 7) _____
3) _____ 8) _____
4) _____ 9) _____
5) _____ 10) _____

List any medications you are ALLERGIC or sensitive to: _____

Past Hospitalizations (When, where and for what):

_____
_____
_____
_____
_____

Outpatient Surgeries (When, where and for what):

_____
_____
_____

Name of family physician:_____
Address:_____
Phone:_____ Date of your last medical check-up:_____

Medical Testing

Check all medical tests that have been performed in the past 6 months, and report any abnormal findings:

	Check here if normal	Abnormal findings
☐ Angiography	☐	_____
☐ Blood work	☐	_____
☐ Brain scan	☐	_____
☐ CT scan	☐	_____
☐ EEG	☐	_____
☐ Lumbar puncture or spinal tap	☐	_____
☐ Magnetic Resonance Imaging (MRI)	☐	_____
☐ Neurological office exam	☐	_____
☐ PET scan	☐	_____
☐ Physicians office exam	☐	_____
☐ Skull x-ray	☐	_____
☐ Ultrasound	☐	_____
☐ Other testing: _____	☐	_____

Family History

Father's Name _____ Age _____ Health Problems _____
Education _____ Occupation _____ Employer _____

Mother's Name _____ Age _____ Health Problems _____
Education _____ Occupation _____ Employer _____

Date of parent's marriage _____ Years married _____ Current marital problems? _____ If separated, give date _____ If divorced, date_____

Previous marriages? (Father) _____ (Mother) _____ Subsequent marriages? (Father) _____ (Mother) _____

Please provide information regarding step-parents if your parents are divorced:

Name	Age	Education	Occupation	Date Married	# Years
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Names and Ages of Brothers and Sisters (Include step-brothers and step-sisters and Half-Brothers and Half-Sisters):

NAME:	AGE:	NAME:	AGE:	NAME:	AGE:
1		4		7	
2		5		8	
3		6		9	

List anyone else who lived in the home during your childhood: _____

List names of any family members (e.g. immediate and distant relatives) with any of the following problems:

Alcohol/drug abuse _____
Criminal history _____
Emotional/behavioral problems _____
Medical problems (e.g. Heart disease, Cancer, Seizures) _____
Learning/developmental problems _____

Marital History

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed ☐ Other: ____________________

Current Marriage

Date of marriage:__________ Number of years married:__________ Date of separation:__________ Date of divorce:__________
Spouse's name: ______________________________ Age:__________ Health: ______________________________
Education: ____________________ Occupation: ______________________________
Type of marital problems: ______________________________
Names and ages of children: ______________________________
If divorced/separated, what is the custody arrangement: ______________________________

Prior Marriage

Date of marriage:__________ Number of years married:__________ Date of separation:__________ Date of divorce:__________
Spouse's name: ______________________________ Age:__________ Health: ______________________________
Education: ____________________ Occupation: ______________________________
Type of marital problems: ______________________________
Names and ages of children: ______________________________
If divorced/separated, what is the custody arrangement: ______________________________

Prior Marriage

Date of marriage:__________ Number of years married:__________ Date of separation:__________ Date of divorce:__________
Spouse's name: ______________________________ Age:__________ Health: ______________________________
Education: ____________________ Occupation: ______________________________
Type of marital problems: ______________________________
Names and ages of children: ______________________________
If divorced/separated, what is the custody arrangement: ______________________________

Prior Marriage

Date of marriage:__________ Number of years married:__________ Date of separation:__________ Date of divorce:__________
Spouse's name: ______________________________ Age:__________ Health: ______________________________
Education: ____________________ Occupation: ______________________________
Type of marital problems: ______________________________
Names and ages of children: ______________________________
If divorced/separated, what is the custody arrangement: ______________________________

Prior Marriage

Date of marriage:__________ Number of years married:__________ Date of separation:__________ Date of divorce:__________
Spouse's name: ______________________________ Age:__________ Health: ______________________________
Education: ____________________ Occupation: ______________________________
Type of marital problems: ______________________________
Names and ages of children: ______________________________
If divorced/separated, what is the custody arrangement: ______________________________

List any other marriages and children: ______________________________
____

List names of spouses or children with the following problems:

Developmental/Learning problems: ______________________________
Emotional/Behavioral problems: ______________________________
Alcohol/Drug abuse: ______________________________
Medical problems: ______________________________

Social History

If single or separated, are you currently dating anyone? _____ How long? _____ Is it a serious relationship? _____
First name: _____ Are you currently sexually active? _____ If not dating, when was your last date?_____
How long did you date that person? _____ Was it a serious relationship? _____ First name:_____

Please list "significant others" you have lived with but not married.

Current/Most Recent Cohabitation

Date began:_____ Number of years together:_____ Date ended:_____
Name :_____ Age: _____ Health: _____
Education: _____ Occupation: _____
Type of relationship problems:_____
Names and ages of children: _____
If separated, what is the custody arrangement: _____

Prior Cohabitation

Date began:_____ Number of years together:_____ Date ended:_____
Name :_____ Age: _____ Health: _____
Education: _____ Occupation: _____
Type of relationship problems:_____
Names and ages of children: _____
If separated, what is the custody arrangement: _____

Prior Cohabitation

Date began:_____ Number of years together:_____ Date ended:_____
Name :_____ Age: _____ Health: _____
Education: _____ Occupation: _____
Type of relationship problems:_____
Names and ages of children: _____
If separated, what is the custody arrangement: _____

Have you lived with anyone else in the past? ☐ Yes ☐ No How many times? _____
Any other children outside of marriage? ☐ Yes ☐ No Names/Ages:_____
Any aborted pregnancies/miscarriages? ☐ Yes ☐ No When? _____

List clubs and community/business organizations you are involved with and how often you attend: _____
_____

Are you Religious? ☐ YES ☐ SPIRITUAL ☐ NO If YES: What Faith?: _____
Do you attend church/temple? (where and how often) :_____

What do you do with your free time (including hobbies and extracurricular interests): _____
_____

When was your last vacation (Please describe):_____
_____

How many close friends do you have in the community:_____ How often do you get together with friends or family: _____

How long have you lived in the community:_____ Where have you lived in the past: _____
_____

Educational History

Current grade (Or highest grade/degree completed): _____ Current school: _____
Past schools attended (List in order): _____
_____
Hardest subject(s): _____ Favorite subject(s): _____
Grades earned in elementary school: _____ Junior High GPA _____ High School GPA _____ College GPA _____
Grades repeated: _____ Learning problems (what subjects): _____
Special education placement (Type): _____ During which grades: _____
Extracurricular activities (Music, Sports, Clubs, etc.) _____
Expulsions/suspensions/conduct problems (Type of problem and date): _____
Additional schooling or non-academic training: _____

Occupational History

Present employer: _____ Position: _____
Length of employment: _____ Hours worked per week _____ Current responsibilities: _____

List previous employment for last ten years (Include dates and type of work):

_____
_____
_____
_____
_____

Have you ever been terminated from a job (Please explain):_____
_____

At any time on the job were you ever exposed to dangerous chemicals or substances (e.g., Mercury, Lead, Radiation, Solvents, Pesticides, Chemicals, etc.)?
☐ Yes ☐ No If yes, explain: _____
Have you ever been injured on the job? ☐ Yes ☐ No If yes, explain: _____

Legal History

Present legal problems (Describe): _____
Past arrests (For what?): _____
Convictions (For what?): _____
Time served in juvenile hall, jail or prison (Give dates and locations): _____
_____

Military Service

Branch of service: _____ Dates of service: _____
Job(s) within service: _____
Highest rank: _____ Rank at discharge: _____ Discharge status: _____
Were you exposed to any dangerous or unusual substances (e.g. Agent Orange, Radiation, etc.) ☐ Yes ☐ No
If yes, explain: _____
Did you sustain any physical injuries in the military? ☐ Yes ☐ No If yes, explain: _____