FULLER DIAGNOSTICS, LLC

NEUROPSYCHOLOGICAL EVALUATION PAPERWORK

ADULT FORMS

_____

Name of Patient

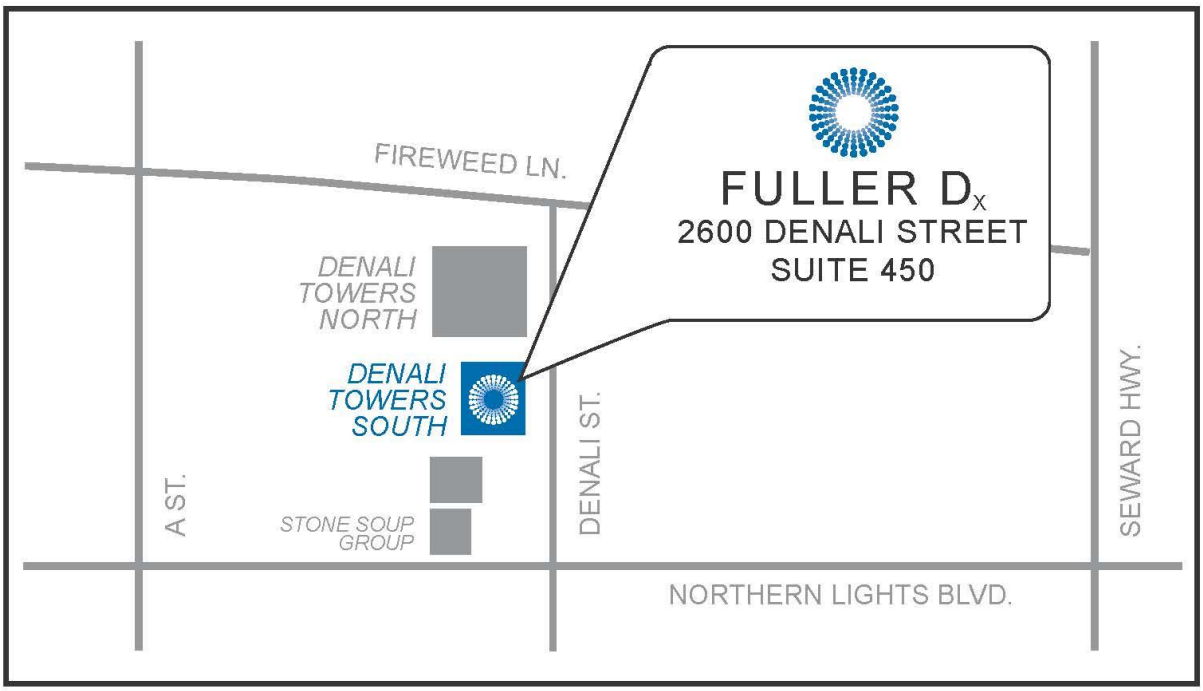
_____ ___/___/_____

Person Completing Date

Fuller Diagnostics, LLC • 2600 Denali Street, Suite 450 • Anchorage, Alaska 99503
Phone: 907.561.0552 *Fax:* 907.561.0562 *Email:* info@fulleralaska.com *Website:* www.fulleralaska.com

FULLER DIAGNOSTICS, LLC

NEUROPSYCHOLOGICAL ASSESSMENT • INDIVIDUAL & FAMILY THERAPY



FULLER DIAGNOSTICS, LLC
2600 Denali Street, Suite 450
Anchorage, Alaska 99503

(907) 561-0552

Fuller Diagnostics, LLC • 2600 Denali Street, Suite 450 • Anchorage, Alaska 99503
Phone: 907.561.0552 *Fax:* 907.561.0562 *Email:* info@fulleralaska.com *Website:* www.fulleralaska.com

FULLER DIAGNOSTICS, LLC

Thank you for choosing FULLER DIAGNOSTICS, LLC. You will need to complete the information packet and return it no later than **TWO WEEKS PRIOR** to the initial scheduled appointment. If for any reason you are unable to complete the paperwork please contact our office. The information you provide will be used during the interview with your provider to better focus the time on specific concerns.

Please return this completed form to our office as soon as possible, you may send it via email, fax or mail.

Email: info@fulleralaska.com **Fax:** 907.561.0562

Mailing Address: Fuller Diagnostics, LLC • 2600 Denali Street, Suite 450 • Anchorage, AK 99503

Included within this packet:

IMPORTANT INFORMATION REGARDING YOUR UPCOMING NEUROPSYCHOLOGICAL EVALUATION

What is a Neuropsychological evaluation?
A Neuropsychological evaluation is a complex process that integrates information from a wide variety of sources. The evaluation examines cognitive abilities, brain-behavior relationships, behavioral and adaptive functioning, and psychological/personality factors. The comprehensive nature of the evaluation enables more accurate diagnoses, determines areas of strength and weakness, and provides specific recommendations based on your needs.

Who is involved in my care?

Clinical Neuropsychologist – Richard D. Fuller, Ph.D. is a clinical neuropsychologist who provides comprehensive evaluations for adolescents, adults and geriatrics.

Clinical Psychologist – Jaime Spatrisano, Ph.D. is a clinical psychologist who specializes in providing comprehensive evaluations to adolescents and young adults. She is currently completing her post-doctoral fellowship in clinical neuropsychology at Fuller Diagnostics, LLC.

Psychometrist – A professional who administers standardized Neuropsychological tests under the supervision a Fuller Diagnostics Provider.
Please note: the Psychometrist cannot provide any information about test results or diagnosis.

What does the process look like?
Interview- Your Fuller Diagnostics Provider will meet with you for approximately one hour to obtain information regarding the difficulties you may be experiencing.

Assessment – The duration of the testing process varies based on the nature of the referral question, complexity of the situation and the patient's age. Testing is completed in morning and afternoon sessions. A lunch break is offered and other breaks as necessary are given. Results of standardized testing are then scored and interpreted in conjunction with additional information obtained during interview, record review, and any significant other input.

Feedback – Adults who wish to schedule a feedback session to better understand their report can contact the scheduler. Feedback appointments are not necessary for all adult patients, but are recommended for those who need assistance understanding their report or have further follow-up questions.

Comprehensive Report- A final comprehensive written report is typically available four to six weeks after the final date of service. The report is mailed out to you and faxed to the referring provider.
Please note: this is an additional date of service billed to insurance and could result in additional patient copay's or co-insurance.

How do I prepare for the evaluation?
- **Arrive 15 minutes early** for your appointment.
- Make sure to get plenty of sleep the night before the appointment and eat a good breakfast.
- If traveling from out of town, please arrive at least one day prior to ensure a good night's sleep.
- Bring any hearing aids, contact lenses or glasses, additionally bring any snacks if desired.

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____

DOB: _____ SSN: _____ Gender: M / F / O

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Name & Phone: _____ Relation to Patient: _____

Email address: _____

☐ I authorize the use of this email address for scheduling and billing purposes

PARENT/GUARDIAN/RESPONSIBLE PARTY (if applicable):

Last Name: _____ First Name: _____ M.I.: _____

Relation to Patient: _____ *Photo ID and Proof of Guardianship Required*

***Any patient under the age of 18 and those requiring a guardian beyond the age of 18 must have their guardian available during the evaluation process.*

Marital Status: M / S / D SSN: _____ DOB: _____ Gender: M / F / O

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer's Name & Phone: _____

PRIMARY INSURANCE - *ALL INFORMATION MUST BE PROVIDED*

Insurance Name: _____

Claims Address: _____

Policy #: _____ Group #: _____ Effective Date: _____

Policy Holder Name: _____ Relation to Patient: _____ Gender: M / F / O

DOB: _____ SSN: _____Employer Name & Phone: _____

SECONDARY INSURANCE – *IF APPLICABLE, ALL INFORMATION MUST BE PROVIDED*

Insurance Name: _____

Claims Address: _____

Policy #: _____ Group #: _____ Effective Date: _____

Policy Holder Name: _____ Relation to Patient: _____ Gender: M / F / O

DOB: _____ SSN: _____Employer Name & Phone: _____

TERTIARY INSURANCE – *IF APPLICABLE, ALL INFORMATION MUST BE PROVIDED*

Insurance Name: _____

Claims Address: _____

Policy #: _____ Group #: _____ Effective Date: _____

Policy Holder Name: _____ Relation to Patient: _____ Gender: M / F / O

DOB: _____ SSN: _____Employer Name & Phone: _____

CLINIC POLICIES

Thank you for choosing FULLER DIAGNOSTICS, LLC we look forward to working with you. The purpose of this form is to provide you with important information regarding confidentiality and responsibility for payment of services.

CONFIDENTIALITY: The information discussed in the Neuropsychological evaluation will be incorporated into the Neuropsychological evaluation report. Information obtained during the current evaluation is considered confidential and can generally only be released to other parties with your written permission. If you disclose information about the abuse of child, vulnerable adult, or elder, then we are required by law to report this to the appropriate authorities. Additionally, if you threaten to harm yourself, someone else, or the property of others, we may be required to notify the police and potential victim(s), or take other reasonable steps to prevent the threatened harm. Finally, if ordered by the court, we may have to testify or release your records. Please ask the front desk staff for a release of information (ROI) if you want us to be able to speak with additional family members or providers other than the referral source about your care. We will forward a copy of the final report with the results to the referral source after the evaluation.

Responsible Party initials ____

CANCELLATIONS/NO-SHOW: We complete a courtesy reminder call and email in advance for each appointment. You are responsible for confirming your appointment by responding to the phone call or email. If you are cancelling your testing appointment, you ***MUST*** do so at least 48 business hours in advance, directly with a staff member during business hours, otherwise you will be charged a "No Show/Late Cancel" fee of $500.00. For interview and feedback appointments, the appointment ***MUST*** be cancelled with at least 48 business hours' notice, or you will be charged a fee of $50.00. If the initial interview appointment is missed, the testing session will be rescheduled, which typically results in a very substantial delay. Please note insurance will not cover "No Show" fees. These fees will not be removed regardless of the reason the appointment was missed, and must be paid in full prior to rescheduling appointments.

Responsible Party initials ____

FINANCIAL: As a courtesy, we will bill your insurance if you provide **accurate proof of coverage** at the time of service. You are expected to pay any/all deductibles and co-pays at the time of service. **You are responsible for paying any balance that is not covered by your insurance.** We accept cash, check, Visa, MasterCard and American Express. Billing statements and receipts will be sent electronically if an email address has been provided. Your provision of the email address shall be considered your consent. If you fail to pay your final bill or to make financial arrangements to settle your account within thirty (30) days of receiving your statement, your account will be sent to a collection agency.

Responsible Party initials ____

FIREARMS/WEAPONS POILCY: It is FULLER DIAGNOSTICS, LLC's policy that all weapons including concealed firearms are prohibited on our premises. The State of Alaska Department of Public Safety dictates that the owners or management of facilities, may deny concealed carry on their premises.

Responsible Party initials ____

GUARANTEE OF PAYMENT/ASSIGNMENT OF BENEFITS: In order to bill my insurance, I understand that they will have access to reports from services provided by FULLER DIAGNOSTICS, LLC. I authorize the exchange of information necessary for payment of services. I authorize payment directly to FULLER DIAGNOSTICS, LLC for services rendered to me regarding my evaluation. I also understand that I am responsible for any amount not covered or that is deemed over usual and customary fees by my insurance carrier or agency. **Self-paying patients:** I understand that I am responsible for my bill and that 50% of total charge must be paid two weeks prior to evaluation, and the remainder no later than the day of testing.

Responsible Party initials ____

AMENDMENT POLICY: It is FULLER DIAGNOSTICS, LLC policy that patient records are generally not amended if the requested change does not directly affect the diagnosis and/or treatment recommendations. Exceptions to this policy include factual errors in background information, or when the neuropsychologist notes that an addendum will be provided upon receipt of additional information in the initial written report. All requests for additions and/or changes are to be placed in writing to be authorized by Dr. Fuller. I acknowledge this policy and understand that any request to amend my final Neuropsychological evaluation will be denied if the requested information to be changed does not directly affect the diagnosis or treatment recommendations.

Responsible Party initials ____

EMAIL REPORT RELEASE: I give permission for the final report to be emailed to the following addresses: *Please ask for password protected if needed, email is not secure otherwise*

_____

_____

Responsible Party initials ____

FULLER DIAGNOSTICS, LLC clinic policies and privacy practices have been reviewed, understood, and agreed to by me.

Patient Name [print]: _____

Responsible Party Name [print]: _____

Responsible Party Signature: _____ Date: _____

CONSENT FOR NEUROPSYCHOLOGICAL EVALUATION

Please read this document carefully, as your signature will represent an agreement between you and FULLER DIAGNOSTICS, LLC.

Please be aware that you are encouraged to have a family member/significant other present during the interview to help provide information regarding your functioning, but they may not be present during the testing. It is also the policy of this office and American Academy of Clinical Neuropsychologists/National Academy of Neuropsychology guidelines that third-party observers (e.g., attorney, advocates, etc.) or recording devices are not allowed during the interview or testing.

The evaluation will include an interview, record review, and testing that will include, but not limited to, assessment of attention, motor skills, sensory abilities, language skills, problem solving, memory, intellectual functioning and emotional or personality functioning. The testing will be scheduled for a full day, with breaks as needed. There will be a break for lunch.

After the test results are obtained, your FULLER DIAGNOSTICS, LLC Provider will interpret this information and results will be formatted into a comprehensive written report. The report will contain test data, provide detailed analysis, and integrate findings across information sources. The report will provide DSM-V-TR/ICD-10 diagnoses, and offer relevant recommendations.

I understand that if I am giving consent for someone over the age of 18 for whom I have legal guardianship, it is incumbent upon me to inform any other legal guardian prior to giving consent and my signature below constitutes my attestation to having full authority and agreement on the part of all parties involved for consenting to the Neuropsychological evaluation process. I hereby release FULLER DIAGNOSTICS, LLC and shall hold them harmless from any obligation, real or implied to inform any other legal guardian or obtain additional consent from any other party as my signature shall serve as permission granted by all parties involved and I will assume full responsibility for any other legal guardian's consent.

I understand that I have the right to terminate the evaluation whenever I wish. I also recognize that in taking such action, the Neuropsychologist will be limited in his/her ability to complete the evaluation, generate a report, or provide valuable information requested by your health care provider. I understand the Neuropsychologist also has the right to terminate the evaluation at any point should he/she become aware of any pending litigation, i.e., open custody cases, contested guardianship cases, worker's comp. etc., for which their report may be used. In which case, the evaluation will not be completed, a report will not be issued, insurance will not be billed and the patient will be solely responsible for payment of the time spent prior to the discovery of the undisclosed legal issues.

The terms of this evaluation have been reviewed, understood, and agreed to by me.

Patient Name [print]: _____

Responsible Party Name [print]: _____

Responsible Party Signature: _____ Date: _____

LIMITS OF CONFIDENTIALITY

Information obtained during the course of the Neuropsychological evaluation will be incorporated into a comprehensive written report that will be sent to the referring clinician and any other individuals/agencies identified on a Release of Information (ROI) signed prior to the evaluation. NOTE: A hard copy will be mailed to the patient or emailed if preferred.

If the fee for this evaluation is being paid by an insurance company or other agency, it may be necessary to send a copy of the report to that agency to secure reimbursement, as noted in the signed Guarantee of Payment/Assignment of Benefits.

This report, and any other information discussed in the evaluation, is confidential, and it will not be shared without written permission except under the following conditions:

- The patient threatens suicide.
- The patient threatens harm to another person(s), including murder, assault, and/or other harm.
- The patient reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
- The patient reports abuse of the elderly.

State law mandates that mental health professionals may need to report these situations to the appropriate persons or agencies.

Communications between FULLER DIAGNOSTICS, LLC and the patient will otherwise be deemed confidential as stated under Alaska State Law.

Having read and understood the above, I agree to the Limits of Confidentiality.

Patient Name [print]: _____

Responsible Party Name [print]: _____

Responsible Party Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to make changes to this Notice at any time, provided such changes are permitted by applicable law, and to make such changes effective for all health information we may already have about you. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for the purposes of treatment, payment, and health care operations. For example:

Treatment: HIPAA allows us to use and disclose your health information to provide, coordinate, or manage your health care and related services. FULLER DIAGNOSTICS, LLC will not disclose your protected health information without your written or (in rare cases) verbal authorization for release of information, except in cases of emergency.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health care operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, accreditation, certification, licensing, or credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment, or health care operations, **you may give us additional written authorization** to use your health information or to disclose it to anyone for any purpose. **If you give us an authorization, you may revoke it in writing at any time.** Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, *but only if you agree that we may do so.*

Persons involved in care: We may use or disclose health information to notify or assist in the notification of a family member (including identifying or locating), your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common medical practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing health-related services: We will not use your health information for marketing communications without your written authorization.
Required by law: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.
National security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials: health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.
Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, emails, or letters).

PATIENT RIGHTS
Access: You have the right to inspect or copy your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access from us directly, or by using the contact information listed at the end of this Notice. We will charge you a reasonable fee for document production expenses. If you request an alternative format, we will charge a reasonable fee for providing your health information in that format.
Disclosure of Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations, and certain other activities, for the last six years.

HIPAA ACKNOWLEDGEMENT

My signature below acknowledges that I was offered a copy of the FULLER DIAGNOSTICS, LLC's Notice of Privacy Practices. I also acknowledge that pursuant to **Ethical Standard 9.04** "**Release of Test Data,"** the "Psychologists may refrain from releasing test data to protect a parent/patient or others from substantial harm, misuse or misrepresentation of the data or the test, recognizing that in many instances the release of confidential information under these circumstances is regulated by law." It is FULLER DIAGNOSTICS, LLC's standard policy that raw test data will not be released to anyone other than a licensed professional Neuropsychologist qualified to interpret the data. This request must be in writing.

Signature of Acknowledgement _____ Date _____

ADULT HISTORY QUESTIONNAIRE

PLEASE NOTE: THIS FORM MUST BE COMPLETED IN FULL

DEMOGRAPHIC & REFERRAL INFORMATION

Full Legal Name: _____ Date of Birth: _____ Gender: _____

Race/Ethnicity: _____ Primary Language: _____ Years of Education: _____

Which is your Dominant Hand *(please circle)*? Right Left Both

Do you have a court appointed guardian? YES / NO If yes, Guardian Name:_____

Guardian Number: _____ Guardian Email: _____

Who referred you to this evaluation? _____

What are the primary concerns that lead to the referral? _____

_____

On the scale below, how would you rate the severity of your present symptoms?

☐ Mildly Upsetting ☐ Moderately ☐ Severe ☐ Very Severe

☐ Extremely Severe ☐ Totally Incapacitating

FAMILY INFORMATION

Current Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Remarried ☐ Widowed ☐ Committed Relationship

Please list current and previous marriages and/or relationships with significant others:

Name Gender Dates of Relationship

_____

_____

_____

Number of Moves in Childhood: _____ Number of Moves in Adulthood: _____

Children: *(please list biological, step and/or adopted)*

Name Age Gender Grade Relationship

_____

_____

_____

_____

Other People Living in Current Household: *(roommates, family, or friends)*

Name Age Gender Education Relationship to Patient

_____

_____

_____

_____

Parents: Name Age Occupation Race Deceased

Mother: _____ Y / N

Father: _____ Y / N

Stepmother: _____ Y / N

Stepfather: _____ Y / N

Other Primary Caregiver: _____ Y / N

Siblings:

Name Age Gender Education Deceased

_____ Y / N

_____ Y / N

_____ Y / N

_____ Y / N

PRENATAL HISTORY

Place of Birth: _____ Birth Weight *(if known)*: _____ Birth Length: _____

Were you born premature? *(Full-term is 40 weeks)* Y / N

If yes, what was the duration of your mother's pregnancy? _____ *(weeks)*

Did biological mother use alcohol, smoke, or use recreational or prescription drugs during pregnancy? Y / N

If yes, what and how much? _____

Other significant events, complications, or medical procedures during pregnancy: _____

_____

Spontaneous delivery: Y / N Planned C-Section: Y / N Emergency C-Section Y / N

Complications: *(please circle)*

"Blue" baby	Cord around neck	Immature lungs	Brain hemorrhage
Suction required	Oxygen required	Transfusions	Treatment for jaundice

Other complications: *(i.e. infections, birth defects, injury)* _____

_____

NICU or specialized care (incubator, oxygen tank, etc.): Y / N If yes, number of days: _____

Number of days/weeks you were in the hospital after delivery: _____

DEVELOPMENTAL HISTORY

Did you experience delays in achieving your milestones: *(Please circle all that apply)*

Speech/Language Fine/Gross Motor Coordination Toilet Training

Other developmental concerns? _____

_____

As a child did you have any of the following? *(Please circle all that apply)*

High fevers	Allergies	Ear Tubes	Recurrent ear infections
Poor Growth	Surgeries	Meningitis	Seizures
Hearing Problems	Vision Problems	Asthma	Bed Wetting

Please Describe: _____

HISTORY OF EXPOSURE TO TRAUMATIC EXPERIENCES AND/OR ABUSE

Have you ever been exposed to abuse, domestic violence, or other traumatic experiences?

☐ Been Physically Assaulted

By Whom: _____ For how long/how many times? _____

Treated for: _____

☐ Been Sexually Abused

By Whom: _____ For how long/how many times? _____

Treated for: _____

FAMILY PSYCHIATRIC HISTORY *(family defined as siblings, parents, grandparents, aunts/uncles, and first cousins)*

Condition	**Relation** *(Please specify maternal or paternal side)*
Learning Problems:	_____
ADHD:	_____
Bipolar Disorder:	_____
Depression:	_____
Alcoholism:	_____
Drug Addiction:	_____
Epilepsy:	_____
Autism:	_____
Trouble with the Law:	_____
Anxiety:	_____
Perfectionism:	_____
Obsessive Compulsive Disorder:	_____
Speech Problems:	_____
Hearing Problems:	_____
Posttraumatic Stress Disorder:	_____
Tics:	_____
Schizophrenia:	_____
Other Behavior or Emotional Problems:	_____
History of Left-handedness:	_____

FAMILY MEDICAL HISTORY *(family defined as siblings, parents, grandparents, aunts/uncles, and first cousins)*

Condition	**Relation** *(Please specify mother's or father's side)*
Stroke/CVA:	_____
Diabetes:	_____
Heart Disease:	_____
High Cholesterol:	_____
High Blood Pressure:	_____
Alzheimer's Disease:	_____
Dementia:	_____
Parkinson's Disease:	_____
Cancer:	_____
Other Genetic/Neurological Disease:	_____
Thyroid Condition:	_____

MEDICAL HISTORY

Height: _____ Weight: _____

Primary Care Physician: _____

Do you see any other physician/therapist/neurologist than your primary physician? Y / N

If yes, who? _____

Have you ever had any of the following symptoms or medical conditions:

☐ Head Injury (TBI)	☐ Diabetes	☐ Heart Disease
☐ Automobile Accident(s)	☐ Liver or Kidney Disease	☐ Headaches
☐ Neurological Disease or Injury	☐ Stroke	☐ Poisoning
☐ Heart Problems	☐ Prescription Drug Abuse	☐ Toxic Exposures
☐ Near Drowning	☐ Overnight Hospitalizations	☐ Cancer
☐ Alcohol Abuse	☐ High Blood Pressure	☐ Substance Abuse
☐ Blood Disorder	☐ Deafness/Hearing Loss	☐ Visual Problems
☐ Back/Neck Injury	☐ Serious Infection	☐ Meningitis
☐ "Nervous Breakdown"	☐ High Fever	☐ Encephalitis
☐ Obstructive Sleep Apnea	☐ Parkinson's Disease	☐ Poisoning
☐ Seizures	☐ Poor Balance	☐ Constipation
☐ Irritable Bowel Syndrome	☐ Poor Bladder Control	☐ Incontinence
☐ Mild Cognitive Impairment	☐ Postural Orthostatic Tachycardia Syndrome (POTS)	
☐ Paralysis	☐ COVID-19	☐ Other: _____

Any overnight medical hospitalizations? Y / N If yes, please describe: _____

_____

Please list any past surgical procedures:

Surgical Procedure	Date of Procedure	Reason for Surgery

Please list all **CURRENT** medications:

Medication	Dose (Mg)	Frequency (i.e., 1x AM)	Prescribed for

DETAIL OF TRAUMATIC/ACQUIRED BRAIN INJURY OR STROKE *(if applicable)*

Date of Accident/Injury: _____ Details of Accident/Injury: _____

_____

Loss of Consciousness: Y / N Estimated length of unconsciousness: _____

Other specific injuries: _____

Which, if any, of the symptoms below have you experienced since your injury? If they were present before the injury but changed please explain below.

☐ Nausea	☐ Pain in Chest	☐ Vomiting	☐ Anxiety
☐ Ringing in Ears	☐ Decreased Attention/Concentration		☐ Blurred Vision
☐ Fatigue Easily	☐ Decreased Energy	☐ Poor Sleep	☐ Aggression
☐ Headaches	☐ Decreased Sexual Drive	☐ Weight Loss/Gain	☐ Fainting/Blackouts
☐ Mood Swings	☐ Difficulty with Crowds	☐ Depression	☐ Hallucinations

Explain: _____

Changes in:

☐ Speech/Language ☐ Reading ☐ Math Skills ☐ Thinking ☐ Frustration Tolerance

☐ Sense of Smell ☐ Sense of Taste ☐ Anger ☐ Stress Tolerance

Please check any you have experienced or are experiencing now:

☐ Headaches	☐ Dizziness	☐ Fainting Spells
☐ Rapid Heart Beat	☐ Stomach Trouble	☐ No Appetite
☐ Bowel Disturbances	☐ Fatigue	☐ Insomnia
☐ Nightmares	☐ Can't Stay Asleep	☐ Overeating
☐ Restricting Food	☐ Chronic Pain	☐ Hypersomnia
☐ Feel Anxious	☐ Feel Panicky	☐ Tremors/Shakiness
☐ Depressed	☐ Suicidal	☐ Unusually Extreme Temper
☐ Sensitive to Smells	☐ Reduced Sex Drive	☐ Unable to Relax
☐ Hypersexual Behavior	☐ Shy with People	☐ Gambling
☐ Over Ambitious	☐ Can't Make Decisions	☐ Don't Like Weekends/Vacations
☐ Can't Make Friends	☐ Inferiority Problems	☐ Home Conditions Uncomfortable
☐ Can't Keep a Job	☐ Memory Problems	☐ Unable to Have a Good Time
☐ Financial Problems	☐ Concentration Difficulties	☐ Sensitive to Light
☐ Sensitive to Loud Noise	☐ Mania/ Hypomania	☐ Overspending
☐ Panic Attacks	☐ Compulsive Behaviors	☐ Obsessive Thoughts
☐ Fear of Germs	☐ Strong need for order	☐ Other _____

SUBSTANCE USE/ ABUSE HISTORY

Have you ever used any of the following recreational substances? *(Circle all that apply)*

Meth	Cocaine/crack	Gas/inhalants	Pain pills/sedatives
Spice	Mushrooms	LSD	Ecstasy

Other: _____

Do you currently use nicotine? Y / N

If yes, how much? _____ What age did you start? _____

If no, have you ever smoked? Y / N How long since you stopped smoking? _____

Do you currently use marijuana? Y / N

Typical frequency/ quantity of marijuana used? _____ What age did you start? _____

Has your marijuana use ever caused legal or interpersonal problems? Y / N

Explain: _____

Do you currently drink alcohol? Y / N If no, have you ever drank? Y / N

Number of drinks per occasion? _____ Number of drinks per week? _____

Has your alcohol use ever caused legal or interpersonal problems? Y / N

Explain: _____

Are you currently, or have you previously been addicted to prescription drugs? Y / N

If yes, name of prescription drug? _____

Typical frequency/ quantity of substance used? _____ What age did you start? ____

Has your drug use ever caused legal or interpersonal problems? Y / N

If yes, please explain: _____

EDUCATIONAL HISTORY

List schools attended (public or private), grade school through high school:

School Grades City, State

_____

_____

_____

_____

Graduated High School? Y / N GED? Y / N

Estimated High School GPA: _____ Are school records Available? _____

Extra-Curricular Activities: _____

_____

_____

Educational Support Required:

☐ IEP Plan ☐ 504 Plan ☐ Poor Handwriting

☐ Started School Late ☐ Behavior Problems ☐ Speech Therapy

☐ Resource/Special Ed. ☐ Underachiever ☐ Learning Problems

☐ Tutoring ☐ Poor Motivation ☐ Remedial Classes

☐ Held Back/ Repeated Grade # _____ ☐Attention/Concentration Problems

☐ Other: _____

Please explain any of the above: _____

_____

_____

What, if anything, detracted from a successful school experience? _____

_____

Best and worst academic areas: _____

_____

POST-SECONDARY EDUCATION

Trade School/Community College: _____ Academic Focus: _____

Years Attended: _____ Estimated GPA: _____ Certification? _____

University/College: _____ Major/Minor: _____

Years Attended: _____ Estimated GPA: _____ Certification/Degree: _____

Graduate School: _____ Graduate Area of Study: _____

Years Attended: _____ Estimated GPA: _____ Degree/Date: _____

MILITARY EXPERIENCE

Branch: _____ Highest Rank: _____

Specialty Areas: _____

_____

OCCUPATIONAL & PERSONAL HISTORY

Current Occupation: _____ How Long: _____

Current Employer: _____ How Long: _____

Previous Employer: _____ Position: _____ How Long: _____

Previous Employer: _____ Position: _____ How Long: _____

Previous Employer: _____ Position: _____ How Long: _____

Difficulties in the work setting? _____

_____

Hobbies: _____

_____

Recreational Activities: _____

_____

Particular Areas of Interest: _____

_____

Strength and Talents: _____

_____

ADDITIONAL INFORMATION

PLEASE INCLUDE ANY OTHER INFORMATION THAT WILL HELP US BETTER UNDERSTAND YOUR CURRENT CONCERNS.

_____

_____

_____

_____

_____

_____

_____

_____

FULLER DIAGNOSTICS, LLC

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** ___/___/_____

I authorize FULLER DIAGNOSTICS, LLC to release information as stated below from the patient health information record:

Information to be Released From: _____

Information to be Released To: _____

Information to be Released via: ☐ Email ☐ Fax ☐ Mail

Email/Fax Number/ Mailing Address: _____

Information to be Released: _____

Dates of service for information requested:

Beginning: _____ thru _____

Purpose of Release:

☐ Continuing care ☐ Copies for own use ☐ Transfer to another provider

☐ Legal ☐ Coordination with School ☐ Other: _____

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time. I understand that once the information has been released according to the terms of this Authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This Authorization will expire one year from the date signed below unless another date or event is entered here _____.

Sensitive Records may require specific patient authorization. Please check the applicable box below to request the following records:

☐Mental Health Treatment ☐Sexually Transmitted Diseases ☐AIDS/HIV Treatment

☐Alcohol/Drug Abuse Treatment

Name of Responsible Party [print]: _____

Signature of Responsible Party: _____ Date: _____

Relationship to the Patient: _____

To be filled out by FULLER DIAGNOSTICS, LLC:

Date Records were released: _____

Signature of Employee: _____