Premier Health
Premier Physician Network

Clinical Neuroscience Institute
Confidential Patient Intake Form

Brain Mapping Center

In preparation for your evaluation at the Clinical Neuroscience Institute's Brain Mapping Center, please complete all of the following questions. It is important that you answer as completely and with as much detail as possible. Although we prefer that you complete these questions yourself, you may ask a spouse, relative, or significant other for help if needed. Please answer all the questions that pertain to you. This form will be reviewed directly by your doctor prior to your appointment; therefore, it must be submitted at least one week prior to your scheduled appointment. Please set aside approximately 30 minutes to complete this form. We greatly appreciate your cooperation and timeliness.

Patient Name _____
First Name Last Name Middle Initial

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Referred by _____

If another person assisted you in filling out this form, please enter their information below:

Name _____ Relationship to Patient _____

GENERAL INFORMATION

Age _____ Date of Birth ____/____/_____ Sex ❑ Male ❑ Female

Height _____ Feet _____ Inches Weight _____ lbs.

Select One ❑ Left-handed ❑ Right-handed ❑ Mixed

Select One ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Education ❑ Less than High School ❑ High School Graduate ❑ Some College (but no degree)
❑ Associate's Degree ❑ Bachelor's Degree ❑ Master's Degree ❑ Doctoral Degree
❑ Other _____

Did you ever repeat any grades or need extra help in any school subjects (for example, receiving special education services, 1:1 tutoring, or other accommodations)? ❑ Yes ❑ No

If you answered 'Yes', please explain:

Military Service ❑ Yes ❑ No From _____ To _____ Year Branch of Service _____

NEUROPSYCHOLOGICAL HISTORY

Memory (Select what problems or symptoms you have experienced)

❑ Forgetting things that you hear and/or read seconds to several minutes later
❑ Forgetting partial or entire conversations from that day or the day before
❑ Forgetting to take medications
❑ Forgetting to attend appointments
❑ Forgetting the names of friends and/or family members
❑ Forgetting the day, week, month, or year

Attention and Concentration (Select what problems or symptoms you have experienced)

❑ Staying focused at work, home, or school
❑ Distractibility
❑ Sustained attention
❑ Divided attention

Executive Functioning (Select what problems or symptoms you have experienced)

❑ Planning and organizing tasks at work, home, or school
❑ Poor judgment and decision making
❑ Impulsivity
❑ Inhibiting responses
❑ Monitoring your performance on tasks for errors
❑ Beginning tasks

Language (Select what problems or symptoms you have experienced)

❑ Understanding things that people say and/or things that you read
❑ Producing speech
❑ Finding the right word
❑ Tracking conversations
❑ Tracking your own thoughts

Visuospatial (Select what problems or symptoms you have experienced)

❑ Perceiving objects ❑ Recognizing objects ❑ Visual field obstructions

Sensory and Motor (Select what problems or symptoms you have experienced)

❑ Worsening vision ❑ Worsening hearing ❑ Worsening smell ❑ Worsening taste
❑ Decreased grip strength and dropping items ❑ Balance and coordination difficulties
❑ Tremors ❑ Falls

Activities of Daily Living (Select what problems or symptoms you have experienced)

❑ Bathing and/or other matters of hygiene ❑ Feeding and/or dressing yourself ❑ Driving
❑ Managing medications ❑ Managing finances ❑ Cooking
❑ Maintaining a clean household

Approximate date when these problems began ____/____/_____

To the best of your knowledge, what is the cause of these problems? _____

Since you first noticed symptoms, have your symptoms generally ❑ Worsened ❑ Improved ❑ Stayed the same

Have you ever had Neuropsychological testing before? ❑ Yes ❑ No

Approximate date received testing ____/____/_____ Hospital or Facility _____

MEDICAL HISTORY

Do you have a:

Primary Care Physician? ❑ Yes ❑ No Doctor Name _____

Neurologist? ❑ Yes ❑ No Doctor Name _____

Psychiatrist? ❑ Yes ❑ No Doctor Name _____

Psychologist? ❑ Yes ❑ No Doctor Name _____

Have you had any of the following tests performed?

CT/MRI Scan	❑ Yes ❑ No	Date ____/_____ (Month / Year)	Hospital or Facility_____	
EEG	❑ Yes ❑ No	Date ____/_____	Hospital or Facility_____	
Spinal Tap	❑ Yes ❑ No	Date ____/_____	Hospital or Facility_____	
Wada	❑ Yes ❑ No	Date ____/_____	Hospital or Facility_____	

Please rate your overall health at the present time. (Select One) ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Please indicate whether you or a member of your family has ever had any of the following illnesses:

Cancer/Tumor	❑ Self	❑ Family Member	Seizures/Epilepsy	❑ Self	❑ Family Member
Diabetes	❑ Self	❑ Family Member	Learning Disability	❑ Self	❑ Family Member
High Blood Pressure	❑ Self	❑ Family Member	Parkinson's Disease	❑ Self	❑ Family Member
Heart Disease	❑ Self	❑ Family Member	Huntington's Disease	❑ Self	❑ Family Member
Heart Attack/Angina	❑ Self	❑ Family Member	Alzheimer's Disease	❑ Self	❑ Family Member
Lung Disease	❑ Self	❑ Family Member	Genetic Disease	❑ Self	❑ Family Member
Multiple Sclerosis	❑ Self	❑ Family Member	Psychiatric Illness	❑ Self	❑ Family Member
Stroke	❑ Self	❑ Family Member	Depression or Anxiety	❑ Self	❑ Family Member
Other _____				❑ Self	❑ Family Member

Have you ever had a head injury (sometimes referred to as a 'Traumatic Brain Injury (TBI)' or 'Concussion')? ❑ Yes ❑ No

If you answered 'Yes', please provide the following information:

Approximate date of head injury _____

Cause of injury_____

Did you lose consciousness? ❑ Yes ❑ No If 'Yes', how long?_____

Were you taken to the hospital? ❑ Yes ❑ No If 'Yes', which hospital?_____

Did you receive an MRI or CT scan? ❑ Yes ❑ No

Did you notice any changes in your cognition afterwards? ❑ Yes ❑ No

Note: If you have had more than one head injury, your doctor will ask you the same information as above for each head injury.

Do you currently smoke cigarettes? ❑ Yes ❑ No

How many cigarettes do you smoke per day?_____ How many years have you smoked cigarettes? _____

Have you ever been a regular smoker and quit? ❑ Yes ❑ No When did you quit smoking? ____/_____ (Month / Year)

Do you drink alcohol currently? ❑ Yes ❑ No How many alcoholic beverages do you consume per week? _____

Any treatment for alcohol, chemical, or prescription drug dependency? ❑ Yes ❑ No

If you answered 'Yes': Approximately when did treatment occur____/_____ (Month / Year)

Approximately how long were you using this substance? _____

OCCUPATIONAL HISTORY

Please outline your work history, starting with your current job, and then working backwards. If you are retired or unemployed, indicate this in the first row and complete the rest of the table with your previous employment.

Position Title	Date Began Month / Year	Date Ended Month / Year	Position Duties
	/	/	
	/	/	
	/	/	
	/	/	
	/	/	

COMPENSATION & LITIGATION

Are you currently receiving disability compensation as a result of current or past illness (e.g., SSDI)? ❑ Yes ❑ No

If you answered 'Yes', please specify for which condition(s) you receive benefits

Are you currently involved in or planning a lawsuit or other legal action related to the illness for which you are being evaluated? ❑ Yes ❑ No