



5930 E Pima Street Suite 138, Tucson AZ 85712 . phone 520-441-4006 . fax 855-249-5320

### NEUROPSYCHOLOGICAL ASSESSMENT INTAKE FORM

Patient Name: \_\_\_\_\_ DOB (Age): \_\_\_\_\_ (\_\_\_\_)

If a Minor, Parent/Legal Guardian Name(s): \_\_\_\_\_

If parents are separated, briefly characterize the custody arrangement **by specifying who has the right to consent to medical procedures and to receive confidential information regarding the above named patient:** \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

Preferred Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Permission to leave detailed Messages on the Above (circle one):      Yes      No

Brief Description of Primary Concerns (i.e. Why are you seeking evaluation of you or your child?):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you or your child had a neuropsychological evaluation before? (circle one)      Yes      No

If yes, when and by whom?

Date(s) of Previous Evaluation(s): \_\_\_\_\_

Name(s) of Previous Evaluator(s): \_\_\_\_\_

Report(s) Available for Review? (circle one)      Yes      No

If no, are you willing to sign a release so that we can request records? (circle one) Yes No

Please list ALL medications and supplements you are taking at present. Include dosages and the number of times the medication is taken in a single day (e.g., losartan potassium 50 mg daily).

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While the evaluator will be asking you more about this at the time of clinical interview, please list any known medical risk factors below, along with a brief description (e.g., history of closed head injury with loss of consciousness in 2011, known genetic abnormality, etc.).

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Is there anything else you wish to disclose to our office at the outset? In particular, is there anything we should know prior to beginning testing? If so, please list it below and/or alert one of our staff members.

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