Neuropsychology

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

PRESURGICAL 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 Planned Procedures (i.e. Why are you seeking a presurgical evaluation for you or your child?):

_____

_____

Have you (or your child) had a psychological 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 (or your child) 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).

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.).

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 the assessment? If so, please list it below and/or alert our staff.