

GENERAL INFORMATION

1. For your convenience, you may download a map to our office from our website. Our office is located on the east side of Denny's restaurant and parking is located behind the restaurant.
2. It is your responsibility to contact your insurance company to open your case for pre-authorization for treatment and confirm benefits for services before your first appointment. Brain Power Learning Center is recognized as a "Out of Plan" provider of outpatient rehabilitation services, including neuropsychological evaluations and cognitive rehabilitation. Brain Power is not contracted with any HMO's. If you have an HMO, please contact our Office Manager to discuss fees and payment options.
3. Please arrive 10 minutes prior to the first appointment with your paperwork completely filled out (prior to your arrival), along with your insurance card(s) and any other paperwork requested by our office.
4. If a child is being brought to this office for treatment, be sure to bring a copy of the child custody order issued by the court for our records.
5. It is our office policy that you provide us with payment in full at the time of the first visit, unless you are part of a PPO that provides us with a specific co-pay amount which you are required to pay at the time of service. Otherwise, please contact our office in advance of your appointment to be told the exact amount you will need to pay at the time of your first visit. We will bill your insurance and, if they pay for your services, we will apply your initial payment towards your account.
6. If you have any questions, please feel free to contact our office at 559-227-2345.

OFFICE POLICIES

Brain Power would like to welcome you and we are pleased to have you as a patient. We are providing you with this informational letter to help you understand how this office operates. Every effort will be made to treat you with courtesy and respect. Please read this information carefully and write down any questions that you might have so that you can discuss them with the doctor or our staff.

APPOINTMENTS

Patients are seen only by appointment. Before your first visit, please complete all of the forms which have been sent to you and be sure to bring them with you to your first appointment.

You will not be seen by the doctor unless all forms are filled out prior to your visit.

This will allow the office staff and doctors to serve you in the most time efficient manner possible. If this information cannot be completed prior to your appointment, please arrive one hour early in order to complete the forms. If they are already completed, **please arrive 15 minutes before your first appointment** so that the staff can prepare your chart.

Upon arrival at the office for any appointment, always announce yourself to the receptionist so that the doctor can be informed that you have arrived.

Initial interviews and therapy visits will last about 55 minutes. Other types of evaluation and testing may involve greater amounts of time. This will be discussed with you by the doctor.

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 re-scheduling an appointment.

You will be charged **\$65.00** for missed appointments and appointments which are canceled with less than 24 hours notice. In the case of evaluations where multiple hours of testing have been scheduled, you will be charged **\$65.00/hour**.

EMERGENCIES

If you need to contact a doctor or therapist between sessions, please leave a message with the office or have the doctor paged at (559) 227-2345, and your call will be returned as soon as possible. If an emergency situation arises, please indicate that, "this is an emergency" when leaving your message. Calls made between 5:00 p.m. and 9:00 a.m. should be of an urgent or emergency nature only. In the event that the doctor on call is unable to be reached, then you should call "9-1-1" to access emergency medical services.

CONFIDENTIALITY AND RELEASE OF INFORMATION

Information disclosed within sessions and the written records pertaining to those sessions are confidential and will not be released to anyone without the written consent of the patient or the parent/guardian, in the case of minors and/or dependent adults, except where doctors are mandated by California law to report otherwise confidential information. Circumstances which are required by law to be reported are:

1. Patient's who pose an imminent threat of danger to themselves or 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.

Disclosure may also be required pursuant to a legal proceeding. If you place your mental or physical status at issue in litigation initiated by you, the defendant may have the right to obtain the records and/or testimony from the doctors and therapist who have treated you.

Disclosure of confidential information may be required by your health insurance or workman's compensation carrier, or HMO/PPO/MCO/EAP in order to process your claims. Only the minimum necessary information will be communicated to the carrier. Brain Power has no knowledge or control over what insurance companies do with the information that is submitted and assumes no responsibility for any actions which result from a third party misusing or re-releasing such information without our expressed consent.

As a patient, you have the right to review or receive a summary of your records at any time (with notice of 5 or more working days), except in limited legal or emergency circumstances or when the doctor assesses that releasing such information might be harmful in any way. In such circumstances the doctor may provide the records to a qualified healthcare professional of your choice and that individual may then choose to review the information with you if it is deemed clinically appropriate. You will be charged an appropriate fee for any preparation time which is required to comply with an information request.

All other requests to release information regarding your treatment and your condition must be authorized in writing specifically allowing the release of medical records. Brain Power will provide you with a Release of Information form or you may choose to place your request in writing. There will be no charge for releasing records to other treating medical or mental health professionals. For all other requests to copy records, there will be a minimum charge of \$15.00 to cover the expenses of photocopying, postage and handling.

NEUROPSYCHOLOGICAL COGNITIVE SKILLS TRAINING SERVICES

If you are being seen only for a neuropsychological assessment, you should be aware that the evaluation process can include some tests that are challenging and designed to exceed the limits of your cognitive abilities. Very rarely will you be able to tell if the errors you make represent poor performance. Many times people think they have done poorly on a test only to find out later that their performance was very good. Dr. Schuyler wants to obtain your best performance because this is the only way to identify your true strengths and weaknesses. Therefore you should report to the person administering the tests any medications taken that day. Problems with fatigue, pain, anxiety, nervousness, frustration, anger and depression could affect your performance and you should communicate any such experiences at the time it is happening so that these problems can be addressed. If necessary, testing will be discontinued for the day in order to avoid having your performance affected by these experiences.

Cognitive skills training is effective only if it is provided in the proper fashion. In order to promote neuroplasticity, the development of new connections between neurons (brain cells) in the brain, training must occur 6-7 days a week utilizing highly structured training activities that become progressively more difficult as the patient improves. Consequently, training always involves hard mental effort every day for a minimum of 3 months when treating learning disorders, to as much as 6 months when treating brain injuries. This represents a significant commitment of time, effort and financial resources to achieve the maximum possible improvement in cognitive abilities. We recommend that you do not undertake this form of treatment unless you are prepared to make this level of commitment.

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, Brain Power 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 Brain Power Neuro Psychological Learning Center, Inc. (dba Brain Power Learning Center).
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 \$15.00 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 Brain Power'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 **\$65/hour** 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

PAYMENT AGREEMENT/AUTHORIZATION TO BILL INSURANCE

Name of Patient: _____
Please print name

"If Minor" Responsible Party Name: _____
Please print name

Our office policy states that if Brain Power Learning Center 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 Brain Power Learning Center 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 (Minor)

Date

RELEASE OF INFORMATION:

Patient Name: _____

I hereby provide authorization for Brain Power Learning Center to exchange information regarding the medical and psychological condition of the patient named above with:

(Name of Patient's Personal Physician)

Signature: _____ Date: ____/____/____

CONSENT FOR TREATMENT

I hereby provide consent for Brain Power Learning Center to provide evaluation and treatment to myself, my minor child, or dependent.

Signature: _____ Date: ____/____/____

DOCTORS NOTES

Symptom Survey

Place a check (✓) beside each symptom that currently applies. Also underline the symptom if it existed previous to the injury/illness.

1) PHYSICAL

- Headaches
- Dizziness
- Nausea
- Vomiting
- Urinary incontinence
- Loss of bowel control
- Excessive tiredness
- Pain (Indicate location): _____
- Blackout spells (fainting)
- Other physical problems: _____

2) SENSORY

Check the side this occurs on:

- | | Right side | Left side | Both sides |
|---|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Loss of feeling or numbness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Tingling or strange skin sensations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Difficulty telling hot from cold | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Problems seeing on one side | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Blank spots in vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Brief periods of blindness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Seeing "stars" or flashes of light | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Double vision | | | |
| <input type="checkbox"/> Difficulty looking quickly from one object to another object | | | |
| <input type="checkbox"/> Difficulty hearing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hearing strange sounds | | | |
| <input type="checkbox"/> Difficulty tasting food | | | |
| <input type="checkbox"/> Difficulty smelling | | | |
| <input type="checkbox"/> Smelling strange odors | | | |
| <input type="checkbox"/> Other sensory problems: _____ | | | |

3) MOTOR AND COORDINATION

Check the side this occurs on:

- | | Right side | Left side | Both sides |
|---|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Fine motor control problems (using a pencil) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Weakness on one side of body | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Difficulty holding on to things | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Tremor or shakiness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Muscle tics or strange movements | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Writing is very small | | | |
| <input type="checkbox"/> Writing is very large | | | |
| <input type="checkbox"/> Walking more slowly than other people | | | |
| <input type="checkbox"/> Balance problems | | | |
| <input type="checkbox"/> Difficulty starting to move | | | |
| <input type="checkbox"/> Jerky muscles | | | |
| <input type="checkbox"/> Muscles tire quickly | | | |
| <input type="checkbox"/> Often bumping into things | | | |
| <input type="checkbox"/> Other motor or coordination problems: _____ | | | |

4) NONVERBAL SKILLS

- Difficulty telling right from left
- Difficulty doing things that s/he should automatically be able to do (e.g., brushing teeth, etc.)
- Problems drawing or copying
- Problems finding way around places that s/he has been before
- Difficulty recognizing objects or people

- Difficulty with puzzles, Legos, blocks, or similar games
- Unaware of things on one side of his/her body: Right side Left side
- Gets lost easily
- Seems unable to recognize facial or body expressions of disapproval or emotions
- Slow reaction time
- Other nonverbal problems: _____

5) SPEECH, LANGUAGE AND ACADEMIC SKILLS

- Unable to speak
- Slurred speech
- Odd or unusual speech sounds
- Difficulty finding the right words to say
- Difficulty expressing thoughts in an organized way
- Difficulty staying with one idea during a conversation
- Difficulty verbally describing the steps involved in doing something
- Difficulty understanding what others are saying
- Difficulty reading phonetically
- Difficulty with reading comprehension
- Difficulty writing letters or words (not due to motor problems)
- Difficulty spelling
- Difficulty with math
- Other speech, language, or academic skills problems: _____

6) CONCENTRATION AND AWARENESS

- Highly distractible
- Loses train of thought
- Problems concentrating
- Becomes easily confused or disorientated
- Mind appears to go blank at times
- Doesn't appear very alert or aware of things
- Other concentration or awareness problems: _____

7) PROBLEM SOLVING

- Difficulty with reasoning or figuring out how to do new things
- Difficulty with planning and organization
- Difficulty figuring out problems that a younger child can do
- Difficulty thinking as quickly as needed
- Difficulty doing things in the right order (sequencing problems)
- Difficulty changing a plan or activity when necessary
- Difficulty completing an activity in a reasonable amount of time
- Difficulty doing more than one thing at a time
- Difficulty switching from one activity to another activity
- Other problem solving difficulties: _____

8) MEMORY

- Forgetting where s/he leaves things (e.g., toys, books, etc.)
- Forgetting names
- Forgetting what s/he should be doing
- Forgetting where s/he is or where s/he is going
- Forgetting events that happened quite recently (e.g., his/her last meal)
- Forgetting events that happened long ago (months or years)
- Needs someone to give a hint so s/he can remember
- Relying more and more on notes or reminders to remember things
- Forgetting the order of things (e.g., when putting something together, etc.)
- Other memory problems: _____

9) BEHAVIOR AND EMOTIONAL FUNCTIONING

- | | |
|---|--|
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Homicidal thoughts |
| <input type="checkbox"/> Depression/sadness | <input type="checkbox"/> Anxiety/nervousness |
| <input type="checkbox"/> Recurrent/intrusive thoughts | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Recurrent/intrusive disturbing recollections or dreams |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Overwhelming need to perform certain behaviors/rituals |
| <input type="checkbox"/> Overeating | <input type="checkbox"/> Excessive fears or phobias |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Significant concerns with physical problems |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Poor frustration tolerance |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Explosive anger |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Rapid mood changes |
| <input type="checkbox"/> Loss of interest in almost all activities | <input type="checkbox"/> Euphoria (feel on top of the world) |
| <input type="checkbox"/> Feeling worthless | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Feelings of hopelessness | <input type="checkbox"/> Decreased need for sleep |
| <input type="checkbox"/> Poor self esteem | <input type="checkbox"/> Aggressive |
| <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Visual or auditory hallucinations |
| <input type="checkbox"/> Anorexia or Bulimia | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Unmotivated | <input type="checkbox"/> Bizarre behavior |
| <input type="checkbox"/> Dependent | <input type="checkbox"/> Shy and withdrawn |
| <input type="checkbox"/> Quiet | <input type="checkbox"/> Self-mutilates |
| <input type="checkbox"/> Resists change | <input type="checkbox"/> Self-stimulates |
| <input type="checkbox"/> Wetting bed or clothes | <input type="checkbox"/> Exhibits sexually inappropriate behavior |
| <input type="checkbox"/> Bowel movements in underwear | <input type="checkbox"/> Risk-taking |
| <input type="checkbox"/> Emotional | <input type="checkbox"/> Is cruel to other people |
| <input type="checkbox"/> Immature | <input type="checkbox"/> Swears a lot |
| <input type="checkbox"/> Is very fidgety | <input type="checkbox"/> Steals things without people knowing on several occasions |
| <input type="checkbox"/> Can't remain seated | <input type="checkbox"/> Breaks into other people's property |
| <input type="checkbox"/> Can't wait his/her turn | <input type="checkbox"/> Easily lies to others |
| <input type="checkbox"/> Answers before s/he hears the whole question | <input type="checkbox"/> Rarely follows other's instructions |
| <input type="checkbox"/> Destroys other people's property | <input type="checkbox"/> Starts fights with others |
| <input type="checkbox"/> Is cruel to animals | <input type="checkbox"/> When fighting, has used a weapon |
| <input type="checkbox"/> Other unusual behavior: _____ | |

10) ACTIVITIES OF DAILY LIVING

- Difficulty dressing
- Difficulty bathing or showering
- Requires assistance for toileting
- Difficulty with grooming (including not attending to the same level of grooming as before)
- Difficulty with eating or feeding self independently, or not attending to table manners as before
- Problems telling time
- Problems keeping track of time (i.e. resulting in missed or late arrival for appointments, classes, or work)
- Unable to drive safely
- Unable to ride a bicycle safely in traffic
- Unable to use of public transportation independently (i.e. school bus for children; city bus or taxi for and adult)
- Problems preparing a simple meal (i.e. sandwich) independently or using a microwave oven for frozen meals
- Problems preparing a complex meal (i.e. complete meal using the stove/oven) independently
- Difficulty preparing a list and shopping independently
- Problems handling cash purchases (i.e. making change)
- Problems writing checks or balancing a checkbook
- Difficulty managing household/personal finances
- Difficulty independently initiating or performing household chores

Medical History

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

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS, ARC or HIV+ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune system disease | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Enzyme deficiency | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Liver disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Abscessed ears | <input type="checkbox"/> Fevers (104 or higher) | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Radiation exposure/therapy |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Head injury or concussion | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Senility (Dementia) |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Metabolic disorder | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Hereditary disorder | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Brain disease/infection | <input type="checkbox"/> Headaches | <input type="checkbox"/> Measles | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Colds (excessive) | <input type="checkbox"/> Huntington's disease | <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Carbon monoxide poisoning | <input type="checkbox"/> Hormone problems | <input type="checkbox"/> Oxygen deprivation | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hazardous substance exposure | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> 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 | ___ UNCLASSIFIED TYPE |
| <input type="checkbox"/> Simple partial (Jacksonian) | <input type="checkbox"/> Absence (Petit mal) | |
| <input type="checkbox"/> Complex partial (Psychomotor) | <input type="checkbox"/> Myoclonic | |
| <input type="checkbox"/> Partial evolving into generalized | <input type="checkbox"/> Clonic | |
| | <input type="checkbox"/> Tonic | |
| | <input type="checkbox"/> Tonic-clonic (Grand mal) | |
| | <input type="checkbox"/> Atonic | |

List any medications currently being taken (over-the-counter or prescription), and the dosage.

Medication and Dosage

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

List any medications you are ALLERGIC or sensitive to: _____

Past Hospitalizations (When, where and for what):

Outpatient Surgeries (When, where and for what):

Medical Testing

Check all medical tests that recently have been done and report any abnormal findings:

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

Identify the physician who is most familiar with your recent problems:

Name of physician: _____
 Address: _____
 Phone: _____ Date of last medical check-up: _____
 Findings of the check-up: _____

Family Physician (if other than above): _____
 Address: _____
 Phone: _____

Other health care professionals currently treating: _____

Have you had a prior psychological or neuropsychological evaluation? Yes ___ No ___

If yes, complete this information:

Name of psychologist: _____
 Address: _____
 Phone: _____
 Date of evaluation: _____ Reason for evaluation: _____
 Findings of the evaluation: _____

DOCTORS NOTES

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: _____

DOCTORS NOTES

Birth and Developmental History

Place of Birth: _____ Were parents married at time of birth? _____

Was mother under a doctors care during the pregnancy? _____ Was the child adopted? _____ If so, at what age? _____

Circle any illnesses during pregnancy:

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

Medications taken during pregnancy: _____

Were drugs or alcohol taken during pregnancy? Yes ___ No ___ If yes, specify: _____

Was there significant emotional stress during pregnancy? Yes ___ No ___ If yes, name stressors: _____

Was the birth: On time ___ Premature ___ (By how long _____) Late ___ (By how long _____)

Was labor: Spontaneous ___ Induced ___ Duration of labor _____ (Hours) Cesarean required? _____

Was the presentation: Normal ___ Breach ___ Transverse (Crosswise) ___ Posterior first ___

Did the baby experience any of these problems: Fetal distress ___ Prolapsed cord ___ Low placenta (Placenta previa) ___

 Premature separation of the placenta (Abruptio placenta) ___ Cord wrapped around neck ___

Any other problems that mother or child had: _____

Was general anesthesia used? _____ Were forceps used? _____ Were there breathing problems? _____

Color at birth: Normal ___ Blue ___ Yellow ___ Was oxygen used (How long)? _____ APGAR Score _____

Birthweight: _____ Length: _____

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:

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:

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

List family members with developmental or learning problems: _____

DOCTORS NOTES

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) _____
If divorced, current custody arrangement _____

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):

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 _____

<p>DOCTORS NOTES</p>

Marital History

Marital Status: Single Married Separated Divorced Widowed

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: _____

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: _____

DOCTORS NOTES

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: _____

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: _____

Do you attend church? (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: _____

DOCTORS NOTES

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 G.P.A. _____ High School G.P.A. _____ 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: _____

DOCTORS NOTES

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: _____

DOCTORS NOTES

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): _____

<p>DOCTORS NOTES</p>

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: _____

<p>DOCTORS NOTES</p>

Adult General Symptom Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List other person _____

0 1 2 3 4 NA
 Never Rarely Occasionally Frequently Very Frequently Not Applicable/Not Known

- | Other | Self | | | |
|--------------------------|--------------------------|--|----|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. depressed or sad mood | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. decreased interest in things that are usually fun, including sex | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. significant weight gain or loss, or marked appetite changes, increased or decreased | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. recurrent thoughts of death or suicide | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. sleep changes, lack of sleep or marked increase in sleep | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. physically agitated or "slowed down" | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. low energy or feelings of tiredness | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. feelings of worthlessness, helplessness, hopelessness or guilt | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. decreased concentration or memory | MD | 5 |

- | | | | | |
|--------------------------|--------------------------|---|----|------|
| <input type="checkbox"/> | <input type="checkbox"/> | 10. periods of an elevated, high or irritable mood | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. periods of a very high self esteem or grandiose thinking | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. periods of decreased need for sleep without feeling tired | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. more talkative than usual or pressure to keep talking | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. racing thoughts or frequent jumping from one subject to another | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. easily distracted by irrelevant things | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. marked increase in activity level | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. excessive involvement in pleasurable activities which have the potential for painful consequences (spending money, sexual indiscretions, gambling, foolish business ventures) | ME | 10,3 |

- | | | | | |
|--------------------------|--------------------------|--|----|------|
| <input type="checkbox"/> | <input type="checkbox"/> | 18. panic attacks, which are periods of intense, unexpected fear or emotional discomfort (list number per month _____) | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. periods of trouble breathing or feeling smothered | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 20. periods of feeling dizzy, faint or unsteady on your feet | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 21. periods of heart pounding or rapid heart rate | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 22. periods of trembling or shaking | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 23. periods of sweating | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 24. periods of choking | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 25. periods of nausea or abdominal upset | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 26. feelings of a situation "not being real" | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 27. numbness or tingling sensations | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 28. hot or cold flashes | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 29. periods of chest pain or discomfort | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 30. fear of dying | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 31. fear of going crazy or doing something uncontrolled | PD | 18,4 |

- | | | | | |
|--------------------------|--------------------------|--|--|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 32. avoiding everyday places for fear of having a panic attack or needing to go with other people in order to feel comfortable | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 33. excessive fear of being judged by others which causes you to avoid or get anxious in situations | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 34. persistent, excessive phobia (heights, closed spaces, specific animals, etc.) please list _____ | | |

- ___ 35. recurrent bothersome thoughts, ideas or images which you try to ignore
- ___ 36. trouble getting "stuck" on certain thoughts, or having the same thought over and over
- ___ 37. excessive or senseless worrying
- ___ 38. others complain that you worry too much or get "stuck" on the same thoughts
- ___ 39. compulsive behaviors that you must do or you feel very anxious, such as excessive hand washing, checking locks, or counting or spelling
- ___ 40. needing to have things done a certain way or you become very upset
- ___ 41. others complain that you do the same thing over and over to an excessive degree (such as cleaning or checking) OC 3

- ___ 42. recurrent and upsetting thoughts of a past traumatic event (molest, accident, fire, etc.)
please list _____
- ___ 43. recurrent distressing dreams of a past upsetting event
- ___ 44. a sense of reliving a past upsetting event
- ___ 45. a sense of panic or fear to events that resemble an upsetting past event 1

- ___ 46. you spend effort avoiding thoughts or feelings associated with a past trauma
- ___ 47. persistent avoidance of activities/situations which cause remembrance of upsetting event
- ___ 48. inability to recall an important aspect of a past upsetting event
- ___ 49. marked decreased interest in important activities'
- ___ 50. feeling detached or distant from others
- ___ 51. feeling numb or restricted in your feelings
- ___ 52. feeling that your future is shortened 3

- ___ 53. quick startle
- ___ 54. feels like you're always watching for bad things to happen
- ___ 55. marked physical response to events that remind you of a past upsetting event, i.e., sweating when getting in a car if you had been in a car accident
- ___ 56. marked irritability or anger outbursts
- ___ 57. unrealistic or excessive worry in at least a couple areas of your life PTS 2

- ___ 58. trembling, twitching or feeling shaky
- ___ 59. muscle tension, aches or soreness
- ___ 60. feelings of restlessness
- ___ 61. easily fatigued
- ___ 62. shortness of breath or feeling smothered
- ___ 63. heart pounding or racing
- ___ 64. sweating or cold clammy hands
- ___ 65. dry mouth
- ___ 66. dizziness or lightheadedness
- ___ 67. nausea, diarrhea or other abdominal distress
- ___ 68. hot or cold flashes
- ___ 69. frequent urination
- ___ 70. trouble swallowing or "lump in throat"
- ___ 71. feeling keyed up or on edge
- ___ 72. quick startle response or feeling jumpy
- ___ 73. difficult concentrating or "mind going blank"
- ___ 74. trouble falling or staying asleep
- ___ 75. irritability GAD 6

__	__	76. trouble sustaining attention or being easily distracted		
__	__	77. difficulty completing projects		
__	__	78. feeling overwhelmed of the tasks of everyday living		
__	__	79. trouble maintaining an organized work or living area		
__	__	80. inconsistent work performance		
__	__	81. lacks attention to detail		
__	__	82. makes decisions impulsively		
__	__	83. difficulty delaying what you want, having to have your needs met immediately		
__	__	84. restless, fidgety		
__	__	85. make comments to others without considering their impact		
__	__	86. impatient, easily frustrated		
__	__	87. frequent traffic violations or near accidents	AAD	5
<hr/>				
__	__	88. refusal to maintain body weight above a level most people consider healthy		
__	__	89. intense fear of gaining weight or becoming fat even though underweight		
__	__	90. feelings of being fat, even though you're underweight	AN	3
<hr/>				
__	__	91. recurrent episodes of binge eating large amounts of food		
__	__	92. a feeling of lack of control over eating behavior		
__	__	93. engage in regular activities to purge binges, such as self induced vomiting, laxatives, diuretics, strict dieting or strenuous exercise		
__	__	94. persistent overconcern with body shape and weight	BN	2
<hr/>				
__	__	95a. involuntary physical movements or motor tics (such as eye blinking, shoulder shrugging, head jerking or picking). How long have motor tics been present? ____ How often? ____ describe _____		
__	__	95b. involuntary vocal sounds or verbal tics (such as coughing, puffing, blowing, whistling, swearing). How long have verbal tics been present? ____ How often? ____ describe _____		
			TD	
<hr/>				
__	__	96. delusional or bizarre thoughts (thoughts you know others would think are false)		
__	__	97. seeing objects, shadows or movements that are not real		
__	__	98. hearing voices or sounds that are not real		
__	__	99. periods of time where your thoughts or speech were disjointed or didn't make sense to you or others		
__	__	100. social isolation or withdrawal		
__	__	101. severely impaired ability to function at home or at work		
__	__	102. peculiar behaviors		
__	__	103. lack of personal hygiene or grooming		
__	__	104. inappropriate mood for the situation (i.e., laughing at sad events)		
__	__	105. marked lack of initiative	PsD	3
<hr/>				
__	__	106. frequent feelings that someone or something is out to hurt you or discredit you		
<hr/>				
__	__	107. do you snore loudly (or do others complain about your snoring)		
__	__	108. have others said you stop breathing when you sleep		
__	__	109. do you feel fatigued or tired during the day	SA	
<hr/>				

- 110. do you often feel cold when others feel fine or they are warm
- 111. do you often feel warm when others feel fine or they are cold
- 112. do you have problems with brittle or dry hair
- 113. do you have problems with dry skin
- 114. do you have problems with sweating
- 115. do you have problems with chronic anxiety or tension

ThyA 2

-
-
- 116. impairment in communication as manifested by at least one of the following: (Check those that apply)
 - delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
 - in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
 - repetitive use of language or odd language
 - lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
 - 117. impairment in social interaction, with at least two of the following: (Check those that apply)
 - marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
 - failure to develop peer relationships appropriate to developmental level
 - lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
 - lack of social or emotional reciprocity
 - 118. repetitive patterns of behavior, interests, and activities, as manifested by at least one of the following: (Check those that apply)
 - preoccupation with an area of that is abnormal either in intensity or focus
 - rigid adherence to specific, nonfunctional routines or rituals
 - repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
 - persistent preoccupation with parts of objects
-
-

Adult Brain System Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List other

	1	2	3	4	NA
0					
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Other Self

- | | | | |
|----|----|--|-------|
| __ | __ | 1. Fails to give close attention to details or makes careless mistakes | |
| __ | __ | 2. Trouble sustaining attention in routine situations (i.e., homework, chores, paperwork) | |
| __ | __ | 3. Trouble listening | |
| __ | __ | 4. Fails to finish things | |
| __ | __ | 5. Poor organization for time or space (such as backpack, room, desk, paperwork) | |
| __ | __ | 6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort | |
| __ | __ | 7. Loses things | |
| __ | __ | 8. Easily distracted | |
| __ | __ | 9. Forgetful | |
| __ | __ | 10. Poor planning skills | |
| __ | __ | 11. Lack clear goals or forward thinking | |
| __ | __ | 12. Difficulty expressing feelings | |
| __ | __ | 13. Difficulty expressing empathy for others | |
| __ | __ | 14. Excessive daydreaming | |
| __ | __ | 15. Feeling bored | |
| __ | __ | 16. Feeling apathetic or unmotivated | |
| __ | __ | 17. Feeling tired, sluggish or slow moving | |
| __ | __ | 18. Feeling spacey or "in a fog" | 8,6,4 |

- | | | | |
|----|----|--|-------|
| __ | __ | 19. Fidgety, restless or trouble sitting still | |
| __ | __ | 20. Difficulty remaining seated in situations where remaining seated is expected | |
| __ | __ | 21. Runs about or climbs excessively in situations in which it is inappropriate | |
| __ | __ | 22. Difficulty playing quietly | |
| __ | __ | 23. "On the go" or acts as if "driven by a motor" | |
| __ | __ | 24. Talks excessively | |
| __ | __ | 25. Blurts out answers before questions have been completed | |
| __ | __ | 26. Difficulty waiting turn | |
| __ | __ | 27. Interrupts or intrudes on others (e.g., butts into conversations or games) | |
| __ | __ | 28. Impulsive (saying or doing things without thinking first) | 8,6,4 |

- | | | | |
|----|----|---|--|
| __ | __ | 29. Excessive or senseless worrying | |
| __ | __ | 30. Upset when things do not go your way | |
| __ | __ | 31. Upset when things are out of place | |
| __ | __ | 32. Tendency to be oppositional or argumentative | |
| __ | __ | 33. Tendency to have repetitive negative thoughts | |
| __ | __ | 34. Tendency toward compulsive behaviors | |
| __ | __ | 35. Intense dislike for change | |
| __ | __ | 36. Tendency to hold grudges | |
| __ | __ | 37. Trouble shifting attention from subject to subject | |
| __ | __ | 38. Trouble shifting behavior from task to task | |
| __ | __ | 39. Difficulties seeing options in situations | |
| __ | __ | 40. Tendency to hold on to own opinion and not listen to others | |

- ___ 41. Tendency to get locked into a course of action, whether or not it is good
- ___ 42. Needing to have things done a certain way or you become very upset
- ___ 43. Others complain that you worry too much
- ___ 44. Tend to say no without first thinking about question
- ___ 45. Tendency to predict fear ACG 10,7,4

- ___ 46. Frequent feelings of sadness
- ___ 47. Moodiness
- ___ 48. Negativity
- ___ 49. Low energy
- ___ 50. Irritability
- ___ 51. Decreased interest in others
- ___ 52. Decreased interest in things that are usually fun or pleasurable
- ___ 53. Feelings of hopelessness about the future
- ___ 54. Feelings of helplessness or powerlessness
- ___ 55. Feeling dissatisfied or bored
- ___ 56. Excessive guilt
- ___ 57. Suicidal feelings
- ___ 58. Crying spells
- ___ 59. Lowered interest in things usually considered fun
- ___ 60. Sleep changes (too much or too little)
- ___ 61. Appetite changes (too much or too little)
- ___ 62. Chronic low self-esteem
- ___ 63. Negative sensitivity to smells/odors DLS 10,7,4

- ___ 64. Frequent feelings of nervousness or anxiety
- ___ 65. Panic attacks
- ___ 66. Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)
- ___ 67. Periods of heart pounding, rapid heart rate or chest pain
- ___ 68. Periods of trouble breathing or feeling smothered
- ___ 69. Periods of feeling dizzy, faint or unsteady on your feet
- ___ 70. Periods of nausea or abdominal upset
- ___ 71. Periods of sweating, hot or cold flashes
- ___ 72. Tendency to predict the worst
- ___ 73. Fear of dying or doing something crazy
- ___ 74. A void places for fear of having an anxiety attack
- ___ 75. Conflict avoidance
- ___ 76. Excessive fear of being judged or scrutinized by others
- ___ 77. Persistent phobias
- ___ 78. Low motivation
- ___ 79. Excessive motivation
- ___ 80. Tics (motor or vocal)
- ___ 81. Poor handwriting
- ___ 82. Quick startle
- ___ 83. Tendency to freeze in anxiety provoking situations
- ___ 84. Lacks confidence in their abilities
- ___ 85. Seems shy or timid
- ___ 86. Easily embarrassed
- ___ 87. Sensitive to criticism
- ___ 88. Bites fingernails or picks skin BG 10,7,4

- ___ 89. Short fuse or periods of extreme irritability
 - ___ 90. Periods of rage with little provocation
 - ___ 91. Often misinterprets comments as negative when they are not
 - ___ 92. Irritability tends to build, then explodes, then recedes, often tired after a rage
 - ___ 93. Periods of spaciness or confusion
 - ___ 94. Periods of panic and/or fear for no specific reason
 - ___ 95. Visual or auditory changes, such as seeing shadows or hearing muffled sounds
 - ___ 96. Frequent periods of deja vu (feelings of being somewhere you have never been)
 - ___ 97. Sensitivity or mild paranoia
 - ___ 98. Headaches or abdominal pain of uncertain origin
 - ___ 99. History of a head injury or family history of violence or explosiveness
 - ___ 100. Dark thoughts, may involve suicidal or homicidal thoughts
 - ___ 101. Periods of forgetfulness or memory problems
- TL 8,6,4
-
-