Long Island
Select Healthcare

# Neuropsychological/ Psychological Evaluation
# Patient Information Form

Date:

## Identifying Information

| Patient's Name: | | DOB: | |
|---|---|---|---|
| Gender: | ☐ Male ☐ Female ☐ Self-Describe: | Age: | |
| Person completing form: | | | |
| Relationship to patient: | | | |

## Referral Source

| Referred by: | |
|---|---|
| Contact Information: | |
| Reason for referral: | |
| | |

## Demographics

**Race**
- ☐ African American/Black
- ☐ American Indian/Alaskan
- ☐ Asian
- ☐ Hawaiian/Pacific Islander
- ☐ White
- ☐ Other:

**Ethnicity**
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown

**Primary Language**
- ☐ English
- ☐ Spanish
- ☐ Sign Language
- ☐ Other:

**Living Situation at Enrollment**
- ☐ Assisted Family Living (AFL)
- ☐ Assisted Living Facility
- ☐ Group home (IRA/ICF)
- ☐ Family home
- ☐ Foster care home
- ☐ Residential School
- ☐ Homeless, sheltered
- ☐ Homeless, unsheltered
- ☐ Independent living
- ☐ Jail
- ☐ Psychiatric hospital
- ☐ Supervised apartment
- ☐ Supported living
- ☐ Other:

**Employment Status**
- ☐ Employed Full Time
- ☐ Employed Part Time
- ☐ Student
- ☐ Day/Vocational Program
- ☐ Supported Employment
- ☐ Volunteer
- ☐ None

## Sensory Limitations

☐ None ☐ Speech ☐ Vision ☐ Hearing ☐ Sensory Integration

Additional details:

## Ambulation

☐ Walks unaided ☐ Walks with assistance ☐ Uses wheelchair ☐ Uses adaptive device

Additional details:

## Primary Mode of Communication

☐ Verbal, sentences
☐ Verbal, phrases and words
☐ Verbal, names/titles/few words
☐ Receptive language difficulties
☐ Difficulty holding conversation
☐ Augmented communication device
☐ Gestures, physical guidance of others
☐ American Sign Language
☐ Other:

## Handedness (Writing or Dominant Hand)

☐ Right ☐ Left ☐ Ambidextrous

## Caregiver Information

**Primary Caregiver** responsible for meeting the individual's basic needs (food, clothing, shelter, etc):

☐ Guardian/Authorized Rep
☐ Other Family Member
☐ Paid Support Staff
☐ Parent
☐ Self

| Name: | | Relationship: | |
|---|---|---|---|
| Email: | | Phone: | |
| Address: | | | |
| **Restrictions on authority:** | | | |

**Does the individual have a secondary caregiver?** ☐ Yes / ☐No (if yes, indicate type of caregiver

☐ Guardian/Authorized Rep
☐ Other Family Member
☐ Paid Support Staff
☐ Parent
☐ Self

## Legal Guardian Information (only if different from above)

| Name: | | Relationship: | |
|---|---|---|---|
| Email: | | Phone: | |
| Address: | | | |
| **Restrictions on authority:** | | | |

## Presenting Problems

☒ Aggression (physical, verbal, property destruction, threats)
☐ At risk of losing placement
☐ Decrease in ability to participate in daily functions
☐ Diagnosis and treatment plan assistance
☐ Family needs assistance
☐ Leaving unexpectedly
☐Weapons in home? If yes, Describe:
☐ Mental health symptoms
☐ Self-injurious
☐ Sexualized behavior
☐ Suicidal ideation/behavior
☐ Transition from hospital
☐ Other:

**Additional details.** When did they begin and for how long?

| |
|---|
| |

## Developmental History

Pregnancy
Birth

Developmental milestones
Early childhood illnesses

## Medical

*If "yes" to any of the conditions below, please describe medications/treatments and any recent changes*

| | No | Yes- Past | Yes- Currently | Specify |
|---|---|---|---|---|
| High or prolonged fever | | | | |
| Frequent ear infections | | | | |
| Head injury | | | | |
| Concussion | | | | |
| Loss of consciousness | | | | |
| Dizziness | | | | |
| Seizures | | | | |
| Heart disease | | | | |
| Thyroid disease | | | | |
| Diabetes | | | | |
| Gastrointestinal problems | | | | |
| Strep throat | | | | |
| Asthma | | | | |
| Allergies | | | | |
| Other: | | | | |

**Changes in the last 6 months**

| (check only one) | Inc. | Dec. | Same |
|---|---|---|---|
| **Energy Level** | ☐ | ☐ | ☐ |
| **Appetite** | ☐ | ☐ | ☐ |
| **Weight** | ☐ | ☐ | ☐ |
| **Sleep Amount** | ☐ | ☐ | ☐ |
| **Sexual Interest** | ☐ | ☐ | ☐ |
| **Sexual Activity** | ☐ | ☐ | ☐ |
| **Cognitive Functioning (memory, focus, etc.)** | ☐ | ☐ | ☐ |
| (check all that apply) | Yes | No | New? |
| **CPAP Machine** | ☐ | ☐ | ☐ |
| **Urinary Incontinence** | ☐ | ☐ | ☐ |
| **Fecal Incontinence** | ☐ | ☐ | ☐ |

**Medical Information**

| | |
|---|---|
| ☐ Allergies | |
| ☐ Asthma | |
| ☐ GERD | |
| ☐ Diabetes | |
| ☐ High Blood Pressure | |
| ☐ Seizure Disorder | |
| ☐ Other: | |

## Psychiatric History

- ☒ Aggression (physical, verbal, property destruction, threats)
- ☐ At risk of losing placement
- ☐ Decrease in ability to participate in daily functions
- ☐ Diagnosis and treatment plan assistance
- ☐ Family needs assistance
- ☐ Leaving unexpectedly
- ☐ Weapons in home? If yes, Describe:
- ☐ Mental health symptoms
- ☐ Self-injurious
- ☐ Sexualized behavior
- ☐ Suicidal ideation/behavior
- ☐ Transition from hospital
- ☐ Other:

## DSM 5 Diagnosis at Enrollment

| | |
|---|---|
| Psychiatric Diagnosis: | |
| IDD Diagnosis: | |
| Medical/Health Conditions: | |
| Social Stressors: | |

## Substance Use/Abuse History

**Drug & Alcohol Use** ☐ No ☐ Suspected ☐ Yes

Describe typical drug, alcohol, or smoking use. Have there been changes in amount or frequency in the last 6 months?

| |
|---|
| |

## Current Medications

Attach additional medication information if necessary. Attach MAR if applicable.

| Medication | Diagnosis/Purpose | Dosage | Compliant? | Side Effects Experienced | Date Started |
|---|---|---|---|---|---|
| | | | ☐ | | |
| | | | ☐ | | |
| | | | ☐ | | |

| | | | ☐ | | |
|---|---|---|---|---|---|
| | | | ☐ | | |
| | | | ☐ | | |

## Legal History

☐ None

| ☐ Probation: | |
|---|---|
| ☐ Parole: | |
| ☐ Other: | |

| Date | Criminal Charge | Outcome/Disposition |
|---|---|---|
| | | |
| | | |

## Education

### Current Educational Activity

☐ High School, full inclusion
☐ High School, partial inclusion
☐ High School, segregated class
☐ Traditional College
☐ Non-Traditional College
☐ Compensatory Education
☐ None
☐ Residential School
☐ Other:

| School Name: | | | Date(s) Enrolled: | | | |
|---|---|---|---|---|---|---|
| Graduated: | ☐ Yes ☐ No | Type of Diploma Received: | ☐ IEP | ☐ Local | ☐ Regents | ☐ None |

### School Setting:

☐ Regular Education Classroom
☐ Integrated Classroom
☐ Separate special ed Classroom
☐ Special school-in district
☐ Special school-out of district
☐ Home Instruction
☐ Other:

**Current IEP Plan?** ☐Yes ☐No Date:
**Current 504 Plan?** ☐Yes ☐No Date:

**Current Grade in school**
☐ Pre-School
☐ Kindergarten
☐ Grade School – Identify Grade (1-12): Enter grade
☐ Not In School
☐ Graduate

## Cognitive/Adaptive Functioning

| Standard IQ Score | Level (Cog/Adapt) | Test(s) Performed | Test Date(s) | Report Available? |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |

## Family History

**Individual's family is:** ☐ Biological ☐ Adoptive

| Relative | Description |
| --- | --- |
| Father | |
| Mother | |
| Brother | |
| Sister | |
| Paternal Grandparents | |
| Maternal Grandparents | |

Other Relatives/Additional Information:

| |
| --- |
| |

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| Name/Title | Signature | Date |
| --- | --- | --- |