**Jay Schneiders, PhD ABPP**

**Complex Case Neuropsychology**

**FOR RETURNING PATIENTS ONLY**

**(2 or more months since last seen by Dr. Schneiders)**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_201\_\_\_\_

**Since your last visit with Dr. Schneiders, have you seen any of the following doctors, or had any of the following procedures done? Please circle all that apply:**

neurologist neurosurgeon psychiatrist /psychologist /counselor pain doctor sleep doctor

brain scan EEG sleep study operation(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When is your next appointment with the doctor who referred you to Dr. Schneiders?**

**Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**201\_\_\_ or: To be arranged; not set up yet.

**Please list all current medications and supplements taken. (Specific doses not needed here.)**

**Have you discontinued or stopped any medications or treatments without discussing them with the prescribing physician or your PCP**? [ ] yes [ ] no Please list, if yes:

**Have you had any falls since you last saw Dr. Schneiders?** [ ] yes [ ] no

**Have you gone to the emergency room since you last saw Dr. Schneiders?** [ ] yes [ ] no

**Have you been hospitalized for any reason since you last saw Dr. Schneiders?** [ ] yes [ ] no

**Have you been given any new medical diagnoses since your last visit here?** [ ] yes [ ] no

If yes, please list here:

**Do you have any new or different symptoms emerge since you were last here?** [ ]yes [ ] no

If yes, please list here:

**Since you last saw Dr. Schneiders, how has your memory and thinking been?**

[ ] About the same overall [ ] Better overall [ ] Worse overall [ ] Unsure

**Since you last saw Dr. Schneiders, how has your mood and/or anxiety been?**

[ ] About the same overall [ ] Better overall [ ] Worse overall [ ] Unsure

**Since you last saw Dr. Schneiders, how is your sleep?** [ ] Same [ ] Better [ ] Worse

*Since you last saw Dr. Schneiders*, please write in the space next to the statement, whether the following symptoms are

**“B”** for better or improved

**“W”** for worse, or more bothersome

**“S”** for about the same as before or in the past

**“N”** for not a problem at all for me

\_\_\_\_**Memory Problems**

\_\_\_\_I am generally more forgetful (where I put things, etc.)

\_\_\_\_I have to make lists or write things down now to remember most things or important things

\_\_\_\_I forget conversations I’ve had now that I wouldn’t have before

\_\_\_\_I have forgotten periods of time from my own life

\_\_\_\_I forget people’s names more often than I used to

\_\_\_\_I forget words I used to know easily while I’m talking

\_\_\_\_I forget what I’m doing in the middle of things now

*Since you last saw Dr. Schneiders*, please write in the space next to the statement, whether the following symptoms are

**“B”** for better or improved

**“W”** for worse, or more bothersome

**“S”** for about the same as before or in the past

**“N”** for not a problem at all for me

\_\_\_\_**Attention & Concentration Problems**

\_\_\_\_I have a hard time focusing on, or tracking, things like reading, conversations, television, etc.

\_\_\_\_I get lost or derailed in the middle of conversations now

\_\_\_\_I space out at times and lose track of what’s going on around me

\_\_\_\_I get distracted more easily now than I used to

**\_\_\_\_Speech & Language Problems**

\_\_\_\_I have more trouble speaking as clearly as I used to

\_\_\_\_I have more trouble finding the words I want to say

\_\_\_\_I have more trouble getting the right word out though I know what I want to say

\_\_\_\_I say the wrong word by accident, rather than the one I wanted to say

\_\_\_\_I have more trouble writing as clearly or well as I used to

\_\_\_\_I have more trouble understanding what I read and/or [\_\_\_] what people say to me than I used to

**\_\_\_\_Perceptual or Visual-Spatial Problems**

\_\_\_\_I have more trouble seeing clearly and well

\_\_\_\_I have more trouble hearing clearly and well

\_\_\_\_I have more trouble finding my way around or get lost now in familiar places

\_\_\_\_I have problems with figuring out directions, and/or [\_\_\_ ] telling left from right

**\_\_\_\_General Thinking and Cognitive Problems**

\_\_\_\_I’m not as organized as I used to be when I do things

\_\_\_\_I have trouble now following through and finishing things I start

\_\_\_\_I get confused while I’m working on things or doing something now

\_\_\_\_I have more trouble planning things than I used to

\_\_\_\_I get confused about things now that I didn’t before

 \_\_\_\_I am having new or more trouble with numbers, figures, arithmetic than I did before

\_\_\_\_My thinking and information processing speed is much slower than it used to be.

**\_\_\_\_\_Driving:** [ \_\_\_] I am driving at this time. [ \_\_\_\_] I am not driving now.

\_\_\_\_I have had, and am having, no problems driving at all.

 \_\_\_\_I have had a ticket or an accident or a fender-bender in the last year.

\_\_\_\_I feel completely safe driving and my family and doctor agree with me about that.

\_\_\_\_I feel completely safe driving, but my family [and/or my doctor \_\_\_\_] doesn’t feel I am.

***SLEEP:***

***Please check all that apply:***

 [ ] People sometimes tell me I stop breathing when I’m asleep for short times.

[ ] I snore at night. [ ] Other people say I snore.

[ ] Sometimes I awaken myself for a moment gasping a little bit or snoring.

[ ] My legs or body move around during the night when I am sleeping or trying to sleep.

[ ] I’ll sometimes feel like I wake up while I’m still asleep and feel paralyzed.

[ ] I talk in my sleep. [ ] I walk in my sleep.

[ ] I have nightmares. [ ] I experience very vivid, intense dreaming.

[ ] I feel sleepy during the day. [ ] I nap during the day.

[ ] I fall asleep in quiet activities like TV or reading.

 [ ] I have trouble falling asleep.

 [ ] I have trouble staying asleep and sleeping through the night.

[ ] I commonly wake up earlier than I want to and can’t get back to sleep

[ ] I take a sleeping pill or medications to help me fall or stay asleep.

[ ] I take medication to keep myself awake or alert during the day.

I have been prescribed CPAP, BiPAP, ViPAP or some other sleep device: **[ ] Yes [ ]No**

***IF YES:***

\_\_\_\_I am unable to tolerate it and cannot use it. \_\_\_\_ I never got it set up.

\_\_\_\_I use it about 1-3 hours a night. \_\_\_\_I use it about 3-5 hours a night.

\_\_\_\_ I use it 6 hours a night or more. \_\_\_\_I always use it throughout the *entire* night.

\_\_\_\_I use it once or twice a month. \_\_\_\_I use it once or twice a week.

\_\_\_\_I use it 3-4 times a week. \_\_\_I use it 5-6 times a week. \_\_\_I use it every single night.

**Mood and Other Symptoms**

Please check any and all that apply:

[ ] I feel reasonably happy or good most of the time.

[ ] I have the normal mix of good days and bad days most people have.

 [ ] I feel sad or depressed most of the day, most days

[ ] I have thoughts of suicide and sometimes I am afraid I might act on them.

[ ] I have thoughts of suicide but know I would never act on them.

[ ] I don’t feel as interested in or get as much pleasure from things and people as I used to.

[ ] I have moments when I get panicky all of a sudden.

 [ ] I feel anxiety or nervousness nearly all the time that really doesn’t ever let up.

[ ] Sometimes I hear things around me other people do not hear (sounds, voices, music, etc.)

[ ] Sometimes I see things around me other people do not see.

[ ] Sometimes I taste or smell things around me other people don’t.

 [ ] Sometimes I have trouble controlling my impulses, which could or does get me into trouble.

[ ] Sometimes I feel disconnected from or ‘out of sync’ with my body.

[ ] I have moments when I seem not aware of what is going on around me; when I seem to “click off.”

[ ] Sometimes things around me don’t feel real, even though I know they are.

I sometimes have angry outbursts.  **[ ] Yes [ ] No**  **If yes:**

[ ] My anger outbursts are *only verbal* (yelling, saying angry things) .

[ ] Sometimes my anger outbursts *become physical* (throwing, hitting people or animals, breaking things, etc.)

  [ ] Sometimes I get so angry that *I think or worry I could possibly hurt or injure someone* if things got out of hand.

**Pain Issues**

[ ] I am experiencing no chronic or acute pain at this time.

[ ] I have pain today.

Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain Level: 1/10 2/10 3/10 **4/10 5/10 6/10 7/10 8/10 9/10**

**Personal Habit Checklist**

How much **caffeine** do you take in every day?

\_\_\_\_\_cups of coffee \_\_\_\_\_cups of tea \_\_\_\_\_\_caffeinated sodas/colas

**Tobacco:** Do you currently smoke? **[ ] Yes [ ] No**

[ ] Tobacco [ ] Marijuana [ ] Both How much a day if so? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you chew tobacco? **[ ] Yes [ ] No** How much a week if so? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you quit smoking or chewing tobacco since you last saw Dr. Schneiders?  **[ ] Yes [ ] No [ ] N/A**

**Alcohol:** Do you drink alcoholic beverages? **[ ] yes [ ] no [ ] I used to but I don’t anymore.**

If you stopped drinking recently, when was *the last time* you had a drink?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you drink *now***, **how many drinks do you have *on an average day*?**

  [ ] more than 24 [ ] 13-24 [ ]9-12 [ ] 5-8 [ ] 3-4 [ ] 1-2

**On your *heaviest* day of drinking in the past year**, how many drinks did you have?

[ ] more than 24 [ ] 13-24 [ ]9-12 [ ] 5-8 [ ] 3-4 [ ] 1-2

**Cannabis:** Do youuse cannabis, marijuanaor CBD at this time**?**

[ ] Yes [ ] No **If** you use cannabis in **any** form, is it: [ ] edible [ ] smoked [ ]other

[ ] Medical (prescribed by medical doctor) [ ] Recreational [ ] Both

If yes, amount used per day on average: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, number of times a day cannabis is used on average: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have *stopped* cannabis use since last here, when was your *most recent* cannabis/marijuana use?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Returning patients: Please check and correct info below:**

**[ ] Address has not changed from prior visit.**

**However, if contact information is new or different, please note here:**

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_201\_\_

New address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: : (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] **Insurance has not changed since prior visit.**

**However, if insurance is new or has changed, please complete here:**

**Primary insurer**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary insurer**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing Office Information/Financial Policy**: *For any questions, please call Sandy at 303-697-4086.* If we are on your insurance plan, we are pleased to bill them for your office visits. However, if you do not have insurance, payment for services are due at the time they are rendered. Our office accepts cash, checks, Mastercard and Visa. Returned checks, and letters to youwhich require Certified Mail, will be subject to a $25.00 service charge. Charges *may* be made for telephone calls with the doctor over 10 minutes in length, additional medical reports, medical records, and in the case of not showing for appointments and for appointments cancelled without 24 hours notice, unless unavoidable illness, hospitalization, storm conditions, etc. make it impossible to make a scheduled session. If for any reason, your insurance company denies your claim, we will make reasonable efforts to help you to appeal that denial if you wish, but you are ultimately responsible for all charges for services rendered. In the extremely unlikely event of collection agency involvement, I acknowledge that the information provided to Dr. Schneiders and his office by me is true and correct to the best of my knowledge. I understand that I am responsible to pay for services rendered including reasonable attorney’s fees and 100% costs of collection in the event of a default. I authorize Dr. Schneiders or his staff to furnish or obtain any and all information concerning his work with me with collection or other agencies affiliated with his practice in the extremely unlikely case of a defaulted claim. I have read the preceding information and I understand my rights as a patient or as the patient’s legally responsible party.

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_