JAY SCHNEIDERS, PHD ABPP
COMPLEX CASE NEUROPSYCHOLOGY

BOARD CERTIFIED IN
CLINICAL NEUROPSYCHOLOGY, AND
CLINICAL HEALTH PSYCHOLOGY

FAX 720-441-0480 - TEL 303.697.4086
3601 SOUTH CLARKSON STREET, SUITE 530 ENGLEWOOD, CO 80113
www.drjschneiders.com

We greatly appreciate your courtesy and assistance…

Your appointment and care are important to us!

Your referring doctor or clinician needs this evaluation to help you with the problems and symptoms you are suffering with and/or are worried about.

Of course, we understand when absolutely unavoidable things come up at the last minute (illness or severe weather conditions) that make it impossible to come in for the time you have scheduled, but we earnestly request that you check your schedule again now and make certain the appointment time you have arranged at our office will work for you:

Please **be sure you haven't inadvertently scheduled other appointments or activities for the time we have set aside to see you.**

(Our office will be unable to fill appointment times with other patients who need to see Dr. Schneiders if yours is cancelled at the last minute, unless we have at least 48 hours notice.)

Thank you! Dr. Schneiders looks forward to meeting you and helping you and your referring doctor(s) with the concerns or problems you have!

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3601 South Clarkson Street, suite 530
Englewood, Colorado 80113

CHECKLIST FOR MEETING WITH DR. SCHNEIDERS:

*Please fill this out and **bring it with you to your appointment with your completed paperwork**:*
Thank you!

[ ] I have completely filled out the pre-meeting questionnaires and paperwork and have them with me.

[ ] I am going to see Dr. Schneiders at his **3601 S. Clarkson Street** office [address above].

***Be sure not to* google the office address! The correct current address is this.**
Or see directions on Dr. Schneiders' website: drjschneiders.com

[ ] I understand there will be a one hour lunch break for appointments that are scheduled to extend from morning until the afternoon.

[ ] I understand there is no restaurant in or very close to Dr. Schneiders' office.

My lunch arrangements are:

[ ] I will be able to drive myself to get my lunch.

[ ] The person coming with me will drive me to get my lunch.

[ ] I am bringing my lunch with me and will eat it there [in the office waiting room or down the street in the park.

[Unfortunately, we do not have public wi-fi, microwave or refrigerator in our building.]

Thank you!

Dr. Schneiders very much looks forward to meeting you at your scheduled appointment day and time…

CONFIDENTIAL

JAY L. SCHNEIDERS, Ph.D., ABPP

3601 SOUTH CLARKSON STREET, SUITE 530 - Englewood, CO 80113

Patient's Name:_____Date:_____2021

Patient's address:_____

City:_____ State _____ Zip_____

Phone: : (H)_____ (C) _____ (W) _____
Ok to leave messages on my email? **[ ] Yes [ ]No** Ok to leave messages on my [ ]Home [ ]Cell

My email address: _____@_____

Date of Birth: _____ Age _____ Soc. Sec.# XXX-XX-___ ___ ___ ___

[ ] single [ ] married [ ] divorced [ ] separated [ ] widowed [ ] life partner

Partner/spouse/caregiver/parent's name:_____

Patient's employer:_____or [ ] None
[ ] Homemaker [ ] Employed full-time [ ] Employed part-time [ ] Student [ ] Disability [ ] Unemployed

Who referred you to Dr. Schneiders?_____

Name of Insured *if different from patient*:_____
Other insured's date of birth_____ Soc Sec #: XXX-XX- ___ ___ ___ ___
Other insured's employer: _____

Is your condition a result of an accident or injury? [ ] Yes [ ] No [ ] Unsure
If yes, date of injury: _____ Are you involved in any lawsuit? [ ] Yes [ ] No
Did an attorney ask you to get this examination or evaluation? [ ] Yes [ ] No

I consider myself: [ ] Hispanic-American [ ] African-American [ ] Caucasian [ ] Asian-American
[ ] Other:_____ [ ] I prefer not to say.

Name of **primary insurer**:_____

Policy number_____ Group number_____

Name of **secondary insurer**:_____

Policy number_____ Group number_____

Acknowledgement of financial responsibility: I understand it is my responsibility to ensure that I have all the necessary referrals and pre-authorizations for my care from Dr. Schneiders. *I understand Dr Schneiders and his practice manager, Sandy, cannot guarantee amount or degree of reimbursement from my insurers, if any.* The information above is accurate and true to the best of my knowledge. I understand I am responsible to pay for services rendered, including reasonable attorneys' fees and 100% costs of collection in the event of a default. I further understand that my account becomes delinquent after 60 days. I also hereby authorize Dr. Schneiders/staff to furnish any/all information to my insurance carriers/Medicare/my referring doctor(s) or clinician, concerning my illness, condition and treatments. I authorize my insurance company to send payment directly to Jay Schneiders, PhD, ABPP.

Signature_____ Date: _____

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To my patients:

Thank you very much for taking the time to complete these pages before coming in for your appointment!

While I understand that paperwork and forms like these are time-consuming, they will very much help me streamline and shorten the time we need to meet together and will make your evaluation with me far better focused and much more complete.

(In general, when people fill out these forms in advance, I find we can shorten their appointment by about an hour on average.)

Not every question here will apply to every person's condition. However, a broader, deeper understanding of who you are as a person, and what you have experienced or gone through in your life will help me better understand you as the individual you are, no matter what symptoms may be bothering or affecting you more specifically.

I also suggest that you take a few minutes to look at my website:

drjschneiders.com

On it you may find answers to questions you might have about your appointment with me and about what a neuropsychologist is and does.

And finally, as a reminder, if you have questions about your insurance coverage or billing issues, please feel free to call my office manager, Sandy, at 303-697-4086 at any point along the way.

I do look forward to meeting you and hope I will be able to help you and your doctor with your problems or concerns.

-- Dr. Jay Schneiders

Goals For Your Consultation / Evaluation
With Dr. Schneiders

Why are you coming in for a consultation with Dr. Schneiders at this time?

(Please check all that apply:)

[ ] I decided to come in for an evaluation by my own decision or request, and for my own specific reasons.

[ ] I do not know why I was referred, or what I am supposed to see Dr. Schneiders about.

[ ] My Dr. _____ told me to see a neuropsychologist.
[ ] My family member(s) wants me to see a neuropsychologist.
[ ] My supervisor, boss or my work wants me to get evaluated.
[ ] My lawyer or attorney wants me to get evaluated.
[ ] My insurance company told me they want this evaluation done.
[ ] Other:

What are your own <u>personal goals</u> for this examination or consultation?

(Please check <u>all</u> that apply:)

[ ] I need an evaluation before I undergo surgery (for example, Deep Brain Stimulation surgery, or other epilepsy/seizure surgery).

[ ] I want to find out why I am having problems with my thinking, memory, etc. and see if they can be helped better than they have been so far.

[ ] I need to have an examination before I can get disability.

[ ] I need disability paperwork filled out.

[ ] I need to have an examination before I can go back to work or school.

[ ] I need to have an examination for a lawsuit or court-case.

[ ] I want a second opinion or another opinion about my condition or problems.

[ ] I want to get my [driver's or pilot's] license back.

[ ] Other:

History of Present Illness or Problem

Being *as specific as you can*, please try to pinpoint *the month and year that you first began* to have **memory, thinking or cognitive changes** or problems, or that you, or your family, or others, *first noticed them changing for the worse*: *[_____/_____]*

If you yourself do not think you have any memory difficulties or any problems with your thinking, but people you know, or your family, or doctor think(s) so, check here: [ ]

Did *memory, thinking and/or cognitive* problems seem to come on

[ ] All at once or [ ] Slowly/gradually or [ ] Both have occurred

Have your *memory, thinking and/or cognitive* problems or changes

[ ] stayed about the same [ ] become worse over time? or [ ] Does not apply

If your problems have become worse over time, has this change been

[ ] rapid/fast [ ] slow/gradual [ ] happening in steps

Are your *memory or other cognitive and thinking problems*

[ ] sometimes better and sometimes worse – they fluctuate or vary at times.
[ ] or, pretty much the same for me all the time now.

If your memory or other thinking problems seem to fluctuate or wax and wane, is it

[ ] During or throughout the day. [ ] Worse at nighttime. [ ] From day-to-day.

If your memory or other thinking problems do seem to fluctuate, on your **best days now,** do you think you are ever able to function at your previous, 100% mental/cognitive usual and typical best?

[ ] Yes [ ]No [ ] Not sure

Have you, or have other people you know, or has your family, noticed any significant changes in your *personality* during this time – that is, are you acting or feeling or behaving *differently* from how you did before?

[ ] Yes [ ] No [ ] Not sure

If yes, what kinds of changes have been noted? (Please circle any that apply)

Anger outbursts Moodiness Irritability Lack of Motivation Impulsivity Apathy Other:

Please *check* which of the following areas or problems are present for you now:

____Memory Problems

____I am generally more forgetful (where I put things, etc.).
____I have to make lists or write things down now to remember where I didn't used to.
____I forget conversations I've had now that I wouldn't have before.
____I've forgotten periods of time from my own life or important things that happened to me or that I did.
____I forget people's names more often than I used to.
____I have more trouble holding ideas or thoughts in my head for more than a moment or two.
____Other:

____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 frequently lose my train of thought.
____I suddenly forget what I'm doing in the middle of things now.
____I get distracted more easily now than I used to.

____Speech & Language Problems

____I have more trouble speaking as clearly or well as I used to be able to.
____I have more trouble *finding* the words I want to say.
____I have more trouble *pronouncing* familiar words at times.
____I sometimes *say the wrong word by accident*, rather than the one I wanted to say.
____I have more trouble writing as clearly or as well as I used to.
____I have more trouble understanding [ ] what I read, and/or [ ] what people say to me than I used to.
____Other:

____Perceptual Problems

____I have more trouble seeing clearly and well.
____I have more trouble hearing clearly and well.
____I have more trouble with [ ] finding my way around and/or [ ] getting lost at times in familiar places.
____I have problems with [ ] figuring out directions, and/or [ ] telling left and right.
____Other:

____General Thinking and Cognitive Problems

____I'm not as organized as I used to be when I do things.
____I have more 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 have trouble shifting from one thing to another (and back) and keeping track of things when I do.
____I am having more trouble with numbers, figures, arithmetic than I did before.
____My thinking and information processing speed is slower than it used to be.

_____Driving: [ ] I am driving at this time. [ ] I am not driving now. *[please check all that apply:]*

____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 safe driving and my family and doctor agree with me about that.
____I feel safe driving, but my family does *not* think that I am.
____I feel safe driving, but a doctor has told me not to drive.

Current Living Situation: **[ ] I am happy with my current living situation.**
[ ] I am not happy about my current living situation.

[ ] I live by myself in my own home, condo or apartment.
or
[ ] I live with my spouse/partner [ ] with other family [ ] with a roommate.

[ ] I live in Independent Living.
[ ] I live in Assisted Living
[ ] I live in a Group Home, Halfway House, or other residential setting.

I have some sort of home health care assistance (someone comes in to help me with my cooking, cleaning, or other aspects of my care): **[ ] Yes [ ] No**

Which of these kinds of specialists have you ever seen? Please check all that apply even if unsure.

___Neurologist [MD or DO]
___Neurosurgeon [MD or DO]
___Psychiatrist [MD or DO]
___Clinical Psychologist for psychotherapy or counseling [PhD or PsyD]
___Neuropsychologist for memory/cognitive testing in the pasts [PhD or PsyD]
___Mental health or marriage counselor or social worker [LPC, LCSW, MA]
___Substance use/abuse counselor [CAC]
___Pain specialist [MD, DO or PhD/PsyD]
___Sleep doctor [MD, DO or PhD/PsyD]
___Physiatrist (rehabilitation doctor) [MD or DO]
___Pastoral Counselor [Rev., Father, Rabbi, Imam, M.Div.]
___Homeopath
___Chiropractor [DC]
___Speech therapist [MS-CCC/SLP]

Which of the following tests have you had?

___MRI of the brain ___CT scan of the brain ___ PET or SPECT brain scan
___EEG (a test of the brain, *not* heart) ___ DaT brain scan
___Memory testing ___a few minutes long and/or ___several hours long

___Biopsy of _____
___Psychological Testing (personality or IQ testing; MMPI. etc.)
___Sleep study or "polysomnogram" (This is an overnight study.)

Do you have a medical marijuana certificate? [ ] yes [ ] no [ ] I've applied for one.

Doctor's who prescribed, if so: _____Reason:_____

Do you use marijuana/cannabis to help treat your medical issues and problems? [ ] Yes [ ] No

If yes, do you use [ ] *Edible* marijuana [ ] *Smoking* marijuana [ ] *CBD / oil*

Please check <u>all</u> that apply:

seizures or epilepsy	___me	___family member
Parkinson's disease	___me	___family member
tremor	___me	___family member
Huntington's disease	___me	___family member
dementia / Alzheimer's disease	___me	___family member
Multiple Sclerosis	___me	___family member
stroke or TIA or brain bleed	___me	___family member
brain surgery and/or brain shunt	___me	___family member
loss of sense of taste or smell	___me	
hypertension/high blood pressure	___me	
high cholesterol	___me	
diabetes [ ] Type I [ ] Type II	___me	
thyroid disease	___me = [ ] hypothyroid [ ] hyperthyroid	
cancer	___me [type:_____]	
heart disease	___me	
liver disease or liver transplant	___me	
kidney disease or kidney transplant	___me	
sepsis/severe body infection	___me	
autoimmune disease	___me [type:_____]	
Fibromyalgia	___me	
Arthritis	___me [ ] Rheumatoid/RA [ ]Osteoarthritis	
Menopause [date of onset:_____]	___me	
brain aneurysm / brain bleed	___me	___family member
brain tumor	___me	___family member
schizophrenia	___me	___family member
bipolar disorder /manic depression	___me	___family member
head injury/concussion/TBI	___me	___family member
asthma/reactive airway disease	___me	
sleep apnea	___me	___family member
narcolepsy	___me	___family member
restless leg syndrome	___me	
COPD / lung disease	___me	
atrial fibrillation or flutter	___me	
heart attack or heart failure	___me	
Covid-19/Corona Virus infection	___me	___family member
alcohol or drug problem	___me	___family member
chronic pain	___me	___family member
suicide/attempt	___me	___family member
psychiatric hospital stay	___me	___family member
anorexia or bulimia (past or present)	___me	___family member

Are there any ***other*** **<u>accidents</u>**, **<u>surgeries</u>**, or **<u>medical problems</u>** you have had or suffered from**? If so please list those here, or continue listing on the back of this page**.

What medications are you currently taking? Please list over the counter and/or all supplements or herbals here as well. (You may bring a list instead of listing here and also use the other side of this page to continue if necessary.)

_____ Dose _____ #Times a day:_____

_____ Dose _____ #Times a day:_____

_____ Dose _____ #Times a day:_____

_____ Dose _____ #Times a day:_____

_____ Dose _____ #Times a day:_____

_____ Dose _____ #Times a day:_____

_____ Dose _____ #Times a day:_____

_____ Dose _____ #Times a day:_____

_____ Dose _____ #Times a day:_____

_____ Dose _____ #Times a day:_____

_____ Dose _____ #Times a day:_____

_____ Dose _____ #Times a day:_____

_____ Dose _____ #Times a day:_____

Are you having any problematic or unpleasant side effects to any medications at this time?

[ ] Yes [ ] No [ ] Unsure

Neuropsychological Issues: History

Were there any complications around or during your birth you know of?
[ ] Yes [ ] No [ ]Unsure

Did you suffer any problems or delays as a child in learning to
[ ] read, [ ] write, [ ] walk, or [ ] talk [ ] None of these

Did you suffer from a learning disability, ADD/ADHD, or problems learning any subjects?
[ ] Yes [ ] No [ ]Unsure If yes, please describe:

Were you ever in special education, speech therapy or ever need tutoring? **[ ] Yes [ ]No**

Were you ever [ ] held back a grade? or [ ] jumped ahead a grade? or [ ] I was neither.

Have you ever had a concussion, been knocked out, or had a traumatic brain injury?
[ ] Yes [ ] No [ ] Unsure

Have you ever been exposed to a toxic chemical such as pesticides, inhalants, Agent Orange or other *without protection*? **[ ] Yes [ ] No [ ] Unsure**

Do you *usually* feel well rested when you awaken in the morning? **[ ] Yes [ ] No**

Please check all that apply:

[ ] I have had a sleep study done at some time in the past.
[ ] 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 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 have very vivid, intense dreaming.
[ ] I feel sleepy during the day. [ ] I nap during the day sometimes.
[ ] I act out my dreams sometimes while I'm still asleep. [ ] I wake up confused sometimes.

[ ] I have trouble falling asleep [ ] I fall asleep in quiet activities like TV or reading.
[ ] I have trouble staying asleep and sleeping through the night.
[ ] I often wake up some hours before I want to and then can't get back to sleep.

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 3-6 hours a night.
____I use it throughout the entire night.
____I use it when I nap. ____I use it when I travel
____I use it about once or twice a month. ____I use it about once or twice a week.
____I use it about 4-5 times a week. ____I use it every night.

Early History

How many brothers _____ and how many sisters _____ do/did you have?
Have any of your siblings died? **[ ] Yes [ ] No [ ] Unsure**
If yes, cause(s):

How would you describe your childhood overall and in general?
[ ] Easy and happy [ ] Sad, hard, or painful [ ] Mixed

Did you experience any of the following? Neglect? **[ ]Yes [ ] No**

Emotional abuse in childhood	**[ ] Yes [ ] No**
Sexual abuse or rape in childhood	**[ ] Yes [ ] No**
Physical abuse or beatings in childhood	**[ ] Yes [ ] No**
Emotional abuse in adulthood	**[ ] Yes [ ] No**
Physical abuse in adulthood	**[ ] Yes [ ] No**
Sexual abuse or rape in adulthood	**[ ] Yes [ ] No**
Assault in adulthood	**[ ] Yes [ ] No**
Other traumas not mentioned above	**[ ] Yes [ ] No**

[*If* you experienced any of those events, do you ever have unwanted memories, intrusive thoughts or feelings about them that come over you sometimes?**]**
[ ] Yes [ ] No [ ] Does Not Apply

[*If* you experienced any of those events, do you ever feel like you are reliving it or them – having a 'flashback'**? [ ] Yes [ ] No [ ] Unsure [ ] Does not apply]**

[Do you have nightmares about them? **[ ] Yes [ ] No [ ] Does Not Apply]**

What kind of student were you overall: **[ ] good [ ] poor [ ] average**

I usually earned or received grades in the **A B C D F** range, overall.

[ ] I was not a very good student but I think I could have been.
[ ] School was hard for me even though I tried and worked hard at it.

Check all that apply:

[ ] I completed high school
[ ] I dropped out but *finished* the _____grade.
[ ] I earned my GED
[ ] I graduated from high school
[ ] I completed ____ years of college
[ ] I completed ____ years of [ ] trade or [ ] business school [ ] nursing school
[ ] I earned the following degrees_____

Did you ever serve in the military? **[ ] Yes [ ] No [ ] Conscientious Objector**

If so, which branch? **[ ] USA [ ] USN [ ] USMC [ ] USAF [ ] USCG**
If so, were you ever in combat? **[ ] Yes: Theatre_____[ ]No**
If so, what kind of discharge did you receive? **[ ] Honorable [ ] General [ ] Other**
If so, do you have a service-connected disability? **[ ] Yes: _____% [ ] No**
If SCD; for**:**_____

Do you speak any languages *fluently* other than English? **[ ]Yes [ ] No**
If *yes*, **what was your *first* spoken language**(s)?_____

Please list the **jobs** have you held, including being a homemaker or a stay-at-home parent:

Do you work at the present time? **[ ] No [ ] Yes: [ ] Part time [ ] Full time**

What is your **current job** *title*, if "yes": _____

If *yes*, are your cognitive or memory problems affecting your work, job or schoolwork?
[ ] Yes [ ] No or [ ] Does Not Apply

If yes, do you feel in danger of losing your job or being demoted? **[ ] Yes [ ] No**

Are you on disability? **[ ] Yes [ ] No** If yes, **[ ] medical [ ] psychiatric**

Are you applying for disability at this time? **[ ] Yes [ ] No [ ] Not sure**

Are you retired? **[ ] Yes [ ] No** If *yes*, retired in what year?_____

Are you married or in an intimate partner relationship at this time? **[ ]Yes [ ] No**

If married *or* in a committed partner relationship now, for how long?_____

Have you been married before? **[ ] Yes [ ] No** If yes, how many times before**?**____

Have you any children? **[ ] Yes [ ] No** If so, ages:_____

How would you describe your *social support and friendship network* of people in your life?

[ ] I have many friends. [ ] I don't have any friends I'm really close to.
[ ] I have a few close friends. [ ] I keep pretty much to myself.

Do you feel your social support system is solid and satisfactory enough for you?
[ ] Yes [ ] No

Have you ever been arrested or convicted of a crime other than a minor (**non**-DUI) traffic offense, or spent any time in jail, prison or in juvenile detention? **[ ] Yes [ ] No**

Mood and Other Symptoms

Please review this list very carefully and 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 don't seem to have many feelings at all these days, up or down.
[ ] 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 have felt or been suicidal at one or more times in the past.
[ ] There has been a time when I cut on myself or injured myself on purpose in some other way.

[ ] I have moments when I feel panicky all of a sudden.
[ ] I feel anxiety or nervousness nearly all the time that really doesn't ever let up.
[ ] Sometimes I feel I have to say, think or do special things to keep something bad from happening.
[ ] I have a terror of closed-in places (such as MRIs), or of needles, or of something else I try to avoid if at all possible because it's so scary.
[ ] I have some behaviors or actions I think are (or others have called) "obsessive" or "compulsive" or "OCD."

[ ] 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.

[ ] I have mood swings that last more than a few hours or a day. **[ ] Yes [ ] No**
If yes, [ ] My mood swings are quick and sudden, or [ ] They are slow and gradual.

[ ] I have worried I might be "bipolar" or "manic depressive."
[ ] I have been diagnosed with bipolar disorder (or manic depression or schizoaffective disorder).
[ ] Sometimes I feel so good or "up" that I go days without sleep, or with only a very little sleep.
[ ] My mind sometimes races extremely fast, or jumps from thing-to-thing-to-thing.
[ ] Sometimes my speech becomes really fast and pressured for days at a time.
[ ] Sometimes I have trouble controlling my impulses, which could or does get me into trouble. My impulsivity occurs around [ ] spending [ ] eating [ ] anger [ ] sex [ ] other:

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

- [ ] My anger outbursts are only verbal (yelling, saying angry things).
- [ ] Sometimes my anger outbursts are physical (throwing, hitting, etc.).
- [ ] Sometimes I get so angry that I think or worry I could possibly hurt or injure someone if things got out of hand.
- [ ] Sometimes I have strong thoughts or urges to harm or kill a person or an animal.

[ ] Sometimes things around me don't feel real, even though I know they are.
[ ] 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."
If *yes:* In these episodes, is there [ ] staring without responding [ ] lip smacking behavior [ ] picking at things for no reason [ ] other:

Personal Habit Checklist

Caffeine:

How much caffeine do you take in every day on average?

_____cups of coffee _____cups of tea _____caffeinated sodas/colas _____other

Tobacco:

Do you smoke? **[ ] Yes [ ] No** How much a day if so? _____

How many years if yes?_____years

Did you smoke in the past but quit? **[ ] Yes [ ] No** When did you quit?_____

How many years before you quit, if yes?_____ Average per day:_____

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

Alcohol:

Do you drink alcoholic beverages? **[ ] Yes [ ] No [ ] I used to but I don't anymore.**

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

If you drank *in the past but not now*, how many drinks did you used to have *on your average day*?

[ ] more than 24 [ ] 13-24 [ ] 9-12 [ ] 5-8 [ ] 3-4 [ ] 0-2

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 [ ] 0-2

On your *heaviest* day of drinking in your whole life, how many drinks did you have?

[ ] more than 24 [ ] 13-24 [ ] 9-12 [ ] 5-8 [ ] 3-4 [ ] 0-2

Have you ever had a DUI or DWAI? **[ ] Yes [ ] No**

If yes, when? _____ How many times? _____

Have you ever attended AA or any other alcohol treatment program? **[ ] Yes [ ]No**

Have you ever had a period of time when you, *or others*, felt you drank too much on a regular basis, or when you binge drank? **[ ] Yes [ ]No** If *yes*, during what years:_____to_____

Have you ever had a "black out" from drinking? **[ ] Yes [ ] No [ ] Unsure**

Other:

Which of the following substances have you used or do you currently use?

	Current/*Now*	Previously/In the *past*	Year *last* used?
[ ] marijuana/pot	**[ ] yes [ ] no**	**[ ] yes [ ] no**	_____
[ ] cocaine	**[ ] yes [ ] no**	**[ ] yes [ ] no**	_____
[ ] heroin	**[ ] yes [ ] no**	**[ ] yes [ ] no**	_____
[ ] methamphetamine/uppers/speed	**[ ] yes [ ] no**	**[ ] yes [ ] no**	_____
[ ] MDMA – ecstasy –"Molly"	**[ ] yes [ ] no**	**[ ] yes [ ] no**	_____
[ ] hallucinogens/LSD/mushrooms	**[ ] yes [ ] no**	**[ ] yes [ ] no**	_____
[ ] IV drugs of any kind - "needles"	**[ ] yes [ ] no**	**[ ] yes [ ] no**	_____
[ ] Opioids *not* prescribed by a doctor	**[ ] yes [ ] no**	**[ ] yes [ ] no**	_____

Have you ever been ***treated** for* a drug use problem? [ ] yes [ ] no

Have ***you*** ever *worried* that you might have had an alcohol or drug use problem? [ ] yes [ ] no

Has ***anyone else*** ever said to you they felt you had a drug or alcohol use problem? [ ] yes [ ] no

Have you ever had a problem with prescription drugs or an addiction to them? [ ] yes [ ]no

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Psychological Care History

Have you ever been seen for detailed memory and cognitive testing or examination before?
[ ] Yes: Approx. date(s)_____ [ ] No [ ] Unsure

Are you currently receiving any mental health care from anyone? **[ ] Yes [ ] No**

Have you ever seen any of the following mental health professionals *at any time in the past,* for a consultation, treatment, care or for an evaluation?

Psychologist (PhD, PsyD) **[ ] Yes [ ] No [ ] Unsure**

Psychiatrist (MD, DO) **[ ] Yes [ ] No [ ] Unsure**

Other psychotherapist (LCSW/MSW, LPC, MA, Psychiatric Nurse, etc.) or substance/alcohol use counselor or therapist (CAC, etc.). **[ ] Yes [ ] No [ ] Unsure**

[ ] I have *never* been in therapy, or had any mental health care in the past of any sort.

Have you ever been hospitalized psychiatrically in the past? **[ ] Yes [ ] No**

Have you ever been administered electroconvulsive shock therapy (ECT)?
[ ] Yes [ ] No If yes, what year(s) _____

Please circle any of the following medications you have ever been prescribed, *whether you are currently taking them or not*:

Antidepressants Anti-anxiety medications Antipsychotic medications

Prozac/fluoxetine Zoloft/sertraline Celexa/citalopram Lexapro/escitalopram

Paxil/paroxetine Elavil/amitriptyline Pamelor/nortriptyline Haldol Seroquel

Abilify Risperdal Zyprexa Clozapine Pristiq Thorazine Mellaril

Luvox Xanax/alprazolam Valium/diazepam Ativan/lorazepam BuSpar Desipramine

Klonopin/clonazepam Ambien/zolpidem Lunesta Rozerem Sonata

Aricept/donepezil Exelon/rivastigmine Namenda/memantine Lithium Depakote/valproate

Cymbalta/duloxetine Imipramine/Pamelor Methadone Vivatrol Antabuse

NuPlazid Savella Fetzima Nardil Serzone Desyrel St. John's Wort Kava

Restoril/temazepam Ritalin/Concerta Adderall Buproprion/Wellbutrin Trazodone

Others not listed:

Colorado Patient Rights Information /

HIPAA Acknowledgment

The State of Colorado mandates that patients be given the following additional information at the start of all psychological care:

Dr. Schneiders' credentials:

Doctoral degree in Clinical Psychology, University of Colorado – Boulder	1985
Colorado License for the Independent Practice of Psychology	#1152, 1987-
Board Certification in Clinical Health Psychology, ABPP	Certificate #4771
Board Certification in Clinical Neuropsychology, ABPP	Certificate #6449

General information:

The practice of psychologists is regulated by the Colorado Division of Registrations: Board of Psychologist Examiners, 1560 Broadway Avenue, #1350, Denver, CO 80202. Phone: 303 – 894 – 7800.

As to the regulatory requirements applicable to mental health professionals: **In Colorado, a Licensed Psychologist must hold a doctorate degree in psychology, complete a one-year full time clinical internship, and have at least one year of post-doctoral clinical supervision. An ABPP Board Certified psychologist must in addition have several additional years in-depth post-graduate training and education in the specialty, and then pass national written and oral examinations in the specialty conducted by peers qualified in the specialty area.**

[A Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters' degree in their profession and have two years of post-masters' supervision. A Licensed Social Worker must hold a masters' degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the appropriate and necessary academic degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training and 1,000 hours of supervised experience. A CAC II must complete additional required training and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health and complete additional required training and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical masters' degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists but is *not* licensed or certified in in any of these fields of practice, and therefore *no degree, training or experience whatsoever is required to call oneself "Registered" in the State of Colorado.* A licensed Psychiatrist must hold a medical or osteopathic degree and have completed a one-year internship followed by a residency in psychiatry.

Any person who alleges that a psychologist or mental health professional has violated the licensing laws related to the maintenance of records of a patient eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the last date of professional clinical contact with a patient, whichever is later. *Patient records may not be retained after seven years following the date when the patient was last seen by Dr. Schneiders.*

Psychology, like medicine, is not an exact science. Neuropsychological and clinical health psychology assessment involves interview, and frequently, tests and procedures which attempt to assess a person's functioning in various arenas: for example, memory, concentration, reasoning, personality function, effort, visual-spatial perception and motor coordination among others. For optimal benefit, these require maximum cooperation and active effort on a patient's part.

You are entitled by law to receive information about methods of assessment and treatment, the nature of any clinical techniques used, the duration of planned care (if known), and about your doctor's fee schedule. You may always seek a second opinion and may terminate any elective treatment with any practitioner at any time.

Dr. Schneiders *strongly* endorses the position that in a professional relationship with *any* health care professional – psychologist, psychiatrist, physician, therapist, counselor, nurse, chiropractor or other – sexual intimacy is *never* appropriate, and should be *always* reported to the appropriate licensing, registration or certification board. *(Such activity is unethical and illegal.)*

Your communications with a psychologist are confidential, although *you should be aware that rare exceptions exist under certain conditions* (described in the more extensive information form provided for you and detailed in the HIPAA Notice of Privacy Rights). Some of these exceptions are listed in Section 12-43-218 and the Notice of Privacy Rights you were provided, and there are other exceptions in Colorado and Federal law. For example,

psychologists are required to report child and elder abuse as well as imminent danger to oneself or others to appropriate authorities. If such an extremely rare legal exception were to arise during patient care, where feasible, you would of course be informed.

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 is due at time they are rendered. Our office accepts cash, checks, Mastercard and Visa. Returned checks, and letters to you that 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, and for additional medical reports, medical records, and in the case of not showing for appointments or 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 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 am attesting that the information provided by me to Dr. Schneiders and his office is true and correct to the best of my knowledge. I understand that I am responsible to pay for all services rendered including reasonable attorney's fee and 100% costs of collection in the event of a default. I authorize Dr. Schneiders and/or his staff to furnish or obtain any and all information concerning his care and work with me with collection or other agencies affiliated with his practice, in the unlikely case of a defaulted claim.

I have read the preceding information, which has been offered/provided verbally, and I understand my rights as a patient or as the patient's legally responsible party.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE HAD OPPORTUNITY TO READ THIS AGREEMENT WITH DR. SCHNEIDERS AND THAT YOU AGREE TO ITS TERMS. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE. ADDITIONAL HARD COPIES OF THE LATTER FORM AND PRACTICE INFORMATION MAY BE DOWNLOADED FROM THE PRACTICE WEBSITE [www.drjschneiders.com] AND ARE ALSO AVAILABLE DIRECTLY FROM DR. SCHNEIDERS AT HIS OFFICE.

Signature_____ Date_____

Printed Name: _____

[Person Signing for the Patient, If Any _____

Relationship to the Patient _____

Are you the *legal* guardian or *legal* conservator *appointed by the Court* for this patient?

[ ] Yes [ ] No [ ] Unsure or [ ] Does Not Apply]

JAY L. SCHNEIDERS, PHD, ABPP
Board Certified in Clinical Neuropsychology & in Clinical Health Psychology
3601 S. Clarkson St., Suite 530, Englewood, CO 80113
Office: 303-697-4086 - Fax: 720-441-0480

Authorization to Exchange Records

This form, when completed and signed by you, authorizes Dr. Schneiders to release and exchange protected information from your clinical record to a person or persons you designate.

I authorize Dr. Jay Schneiders, and/or his practice manager Sandy Valentine, to release & exchange information about my medical/surgical/neuropsychological history, conditions, test results/data, examinations and status. This may include information regarding abuse, drug, legal and alcohol history if any, mental health treatment and psychological/psychiatric conditions, and/or HIV/AIDS or Huntington's disease status if known.

This information may be released to and exchanged with the following:

1) Referring doctor:_____
2) PCP:_____
3) Other doctors, psychotherapist, etc.:_____
_____
4) Hospital(s) or Facilities:_____
5) Other:_____
6) Neuropsychological test data/raw data from previous examination(s) if applicable:
_____

I am authorizing release and exchange of this information *at my request* and of my own free will. This authorization shall remain in effect: [ ] *until I withdraw my permission to release and exchange this information in writing*, or [ ] until: _____

I have the right to revoke this authorization, in writing, at any time by sending written notification to Dr. Schneiders' office. However, my revocation will not be effective to the extent that Dr. Schneiders has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that a psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by any authorized recipient of my information and therefore no longer be protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient **Date**

_____ _____
Or: Signature of Patient's Representative Date

If the authorization is signed by a personal representative of the patient, a formal record of such representative's authority legally to act for the patient must be provided.

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Follow-up Feedback & Review Session

Following your assessment ("testing") session, it will take Dr. Schneiders a certain amount of time to analyze your results, to integrate them with your medical information and record, possibly to obtain further clinical records or reports, and to complete his own report, which is almost always very comprehensive. (He sees one or more patients each day, each of whom requires such a thorough report.)

For that reason, we ask you *not* schedule follow-up appointments with your referring doctor for about 3 weeks to discuss your neuropsychological exam results, *unless you need to see that doctor for any other important medical reason.* Dr. Schneiders does his best to get a full, written analysis and report to referring doctors in about 3 weeks following your appointment with him. [He also believes that your obtaining a clear, detailed understanding of the results of your examination is an extremely important aspect of your neuropsychological work-up.]

For that reason [unless you expressly decide not to return for feedback] we ask that you phone the office following your examination to schedule a one-hour follow-up session for a review and discussion of your results at a mutually convenient time. At that appointment – to which Dr. Schneiders invites you to bring family members or others importantly involved in your life and care if you wish – he will discuss your examination results, give you a copy of his report, and discuss treatment recommendations and options with you.

If you have questions about follow-up or review sessions, please feel free to ask us at any time and we will try to address issues that involve special timing needs, scheduling options, etc., to the best of our ability.

Please indicate your preference
by checking one of the following below:

[ ] I will call the office and schedule a regular *in person* follow-up session to review my test results and to obtain a copy of my final report from Dr. Schneiders.

[ ] I prefer to have a *Telehealth online video session* to review my findings.

[ ] I prefer Dr. Schneiders just send me a copy of his report, and I will contact him if I have any questions after receiving it. Please send my report to me:

[ ] By regular mail to my home. **[ ] Via my email_____@_____**
Note: Email is *not* HIPAA secure/compliant, and requested reports will be sent using security/password protection.

[ ] By confidential and secure FAX: (_ _ _) - __ __ __ - __ __ __ __.
This should *not* be a general office or public FAX or any FAX which others have access to.

[ ] I prefer Dr. Schneiders just send a copy of his report to my doctor(s). I do *not* wish to schedule a follow-up session or to receive a copy of his report.

Your Initials: _____ Printed Name:_____ Date_____2020

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