



JAY SCHNEIDERS, PHD ABPP
COMPLEX CASE NEUROPSYCHOLOGY

3601 SOUTH CLARKSON STREET, SUITE 530 - ENGLEWOOD, CO 80113 – 720-587-7173
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.

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

Please be certain you haven't accidentally scheduled other appointments or activities for the same day and 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.)

A CHECKLIST FOR YOUR MEETING WITH DR. SCHNEIDERS:

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

I have **completely filled out** the attached pre-meeting paperwork and have it with me.

I am seeing Dr. Schneiders at his **3601 S. Clarkson Street, Suite 530** office.

**Be sure *not* to google our address for GPS directions! The correct address is this one.
Detailed map & directions are 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 through 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 lunch if you are scheduled a full day.

The person coming with me will drive me to get lunch (if full day).

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

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

JAY L. SCHNEIDERS, Ph.D., ABPP

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

Patient's Name: _____ Date: _____ 2025

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 associates, Rhea, and/or ABC Billing, 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: _____ 2026

To my patients:

Thank you very much for taking the time to complete these many 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 nurse/office manager, Rhea, at 720-587-7173 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 in 2025s

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

(Please check all that apply:)

- I am coming 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 personal goals for this examination or consultation?

(Please check all 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 Problems

Being as specific as you can, please try to pinpoint *the month and year* **when 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 any *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 do 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 Apathy /Lack of Motivation Impulsivity Other:

Please *circle* Y=yes or N=no for each of the following areas or problems that are present for you now:

___ **Memory Problems**

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

___ **Attention & Concentration Problems**

- Y N I have a hard time **focusing** on, or tracking, things like reading, conversations, television, etc.
- Y N I frequently lose my **train of thought**.
- Y N I get **distracted** more easily now than I used to.

___ **Speech & Language Problems**

- Y N I have more trouble **speaking** as clearly or well as I used to be able to.
- Y N I have more trouble **finding** the words I want to say.
- Y N I have more trouble **pronouncing** familiar words at times.
- Y N I sometimes **say the wrong word by accident**, rather than the one I wanted to say.
- Y N I have more trouble **writing** as clearly or as well as I used to.
- Y N I have more trouble [] **understanding** what I **read** and/or [] **retaining** what I **read**.
- Y N I have more trouble understanding **what people say to me, separate from hearing them ok**.

___ **Perceptual, Visual-Spatial Problems**

- Y N I have **trouble seeing** clearly and well.
- Y N I have had **trouble hearing** clearly and well.
If yes, [] I have had a **hearing test**. [] I have **not** had my hearing tested
- Y N I have been prescribed **hearing aids**. IF YES
[] I wear them every day throughout the day. [] I don't always wear them
- Y N I have **tinnitus** [ringing or buzzing sound] [] in both ears. [] in one ear: **Left. Right**
- Y N I have trouble [] **finding my way around**, and/or [] **get lost** at times in familiar places.

___ **General Thinking and Cognitive Problems**

- Y N I'm not as **organized** as I used to be when I do things.
- Y N I have more trouble **planning** things than I used to
- Y N I have trouble **shifting** from one thing to another (& back) & keeping track of things when I do.
- Y N I am having more trouble with **numbers**, figures, arithmetic than I did before.
- Y N 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. [] I **do** drive, but **only a little**

- Y N I have had, and am having, **no problems** driving at all.
- Y N I have had a ticket or **an accident or a 'fender-bender'** in the last year.
- Y N I feel safe driving, but **my family does not think that I am**.
- Y N A doctor or health care provider has **told me I shouldn't drive**.

Current Living Situation: I am happy with my current living situation as is.
 I am not happy about my current living situation.

I live alone, by myself, in my own home, condo, or apartment.

or

I live with my spouse/partner and other family and 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 regularly 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] or ___ **Psychiatric Nurse Specialist** [RN, MSN, NP, CNS]

___ **Clinical Psychologist** for psychotherapy or counseling [PhD or PsyD]

___ **Mental health/marriage counselor or Clinical Social Worker** [LPC/LMFT, LCSW, MA]

___ **Substance use/alcohol use 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., Pastor, Father, Rabbi, Imam, M.Div.]

___ **Homeopath**

___ **Chiropractor** [DC]

___ **Speech therapist/cognitive therapy** [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

___ **Alzheimer's biomarkers** testing: ___ blood tests ___ spinal tap/CSF

___ **Biopsy** of _____

___ **Psychological Testing** (personality or IQ testing; MMPI. etc.)

Please check all 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 / brain shunt	___me	___family member
Brain aneurysm / brain bleed	___me	___family member
Brain tumor	___me	___family member

Loss of sense of taste smell Recent onset Long-term difficulty

Hypertension/high blood pressure ___me High cholesterol ___me

Diabetes Type I Type II ___me or "pre-diabetes"
Thyroid disease ___me hypothyroid hyperthyroid Hashimoto's

Cancer ___me [type(s):_____]

Heart disease ___me [type:_____]

atrial fibrillation or arrhythmia
 heart attack or heart failure
 valve replacement stenting other_____

Liver disease ___me [type:_____]

Kidney disease or kidney transplant ___me

Autoimmune disease ___me [type:_____]

Sepsis/severe body infection ___me

Fibromyalgia ___me Sjogren's Syndrome ___me

diagnosed by rheumatologist?

Arthritis ___me Rheumatoid/RA Osteoarthritis

diagnosed by rheumatologist?

Menopause [date of onset:_____] ___me Are you on *Hormone Replacement*? Y N

Perimenopausal [date of onset:_____] ___me

Schizophrenia/schizoaffective disorder ___me ___family member

Bipolar disorder / manic depression ___me ___family member

ADD/ADHD ___me Diagnosed in childhood adulthood

Asthma; breathing problems/ RADS ___me

COPD / lung disease ___me

Narcolepsy ___me ___family member

Sleep apnea ___me

Covid-19/Corona Virus infection ___me Approx. Date(s)_____

Eating disorder (past or present) ___me Current Childhood/Adolescence

Please list any *other* accidents, surgeries, or other medical problems 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 of meds instead of listing here and may also **use the other side of this page to continue** if necessary.)

_____ Dose _____ #Times a day: _____

Do you use **cannabis/marijuana** for any medical problems or symptoms? **Yes No**
If yes which form(s):

Edibles Smoking/Vaping Topical CBD [cream]

Do you have a **medical marijuana certificate** signed by a physician? **Yes No**

Are you having any problematic or unpleasant **side effects** to any medications at this time?
 Yes No Unsure

Neuropsychological Issues: History

Do you know of 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 **childhood** learning disability, ADD, or problems learning any subjects?

Yes No Unsure If Yes, Type? _____

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 If "yes", Date(s) _____

Sleep: [Please check all that apply]:

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

I have had a **sleep study** done at some time in the past: home study study in sleep lab
If yes, approximate date(s) _____

People sometimes tell me I momentarily **stop breathing** when I'm asleep.

I **snore** at night. Other people tell me 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 **physically act out my dreams** while I'm still asleep. I wake up **confused** sometimes.

I **feel sleepy** during the day. I **fall asleep in quiet activities** like TV or reading.

I **nap** during the day sometimes. [nap ____ average #days per week. ____ I average #hours per nap.]

I have trouble **falling** asleep

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, and/or Oxygen or some other sleep device:

Yes No

IF YES:

____ I am unable to tolerate it and do not use it.

____ I never got it set up.

____ I use it about 1-3 hours a night.

____ I use it about 4-6 hours a night.

____ I use it throughout the entire night.

____ I use it about once or twice a week.

____ I use it about 4-5 times a week.

____ I use it every night.

____ I use it when I nap.

____ I use it when I travel

____ I take it off during the night without realizing it: most nights some nights

Early History

How many **brothers** _____ and how many **sisters** _____ do/did you have?

Have any of your siblings died? **Yes** **No** **Unsure**

If yes, **who and from what** cause(s):

Do any siblings **also have** memory, thinking or other cognitive problems? **Yes** **No**

How would you describe your childhood *overall* and *in general*?

Easy and happy **Sad, hard, or painful** **Emotionally Mixed**

Did you experience any of the following? Physical 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**

Other 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 again now – having a **'flashback'**? **Yes** **No** **Unsure** **Does not apply**

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

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

I *typically* 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 if _____

School was hard for me even though I tried and worked hard at it.

Please check all that apply:

I graduated from high school.

I dropped out *before graduating* but *finished* the _____ grade.

I earned my GED.

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) at home? _____

Please list your current and/or all significant **jobs** have you've 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 dating or in an intimate partner relationship? 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.

I'm happy with the way things are I wish I had more people closer to me

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 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 feel afraid I might act on them? Yes No
I have **thoughts of suicide** but know I would **not** act on them. Yes No
 I have felt or been suicidal at one or more times **in the past**. Yes No
 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.
 - I have a dread or 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." If yes, please described briefly:
- 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 other people around me 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. Yes. No
If yes: My impulsivity is around spending eating anger sex
- I sometimes have **angry outbursts**. Yes No *If 'yes':*
 - My anger outbursts are **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 another 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."** Yes No Unsure
If yes: During 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? _____

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

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

Do you **chew** tobacco? Yes No **How many cans** a week if so? _____

Alcohol:

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

Average number of **days per week** I will have a drink _____ days a week

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 0

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 0

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 1-2

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 _____

Other:

Which of the following substances have you used and/or do you currently use? *[Please check both columns!]*

	<u>Currently/Now</u>	<u>Previously/In the past</u>	<u>Year last used?</u>
<input type="checkbox"/> marijuana/pot/cannabis	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> cocaine	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> heroin	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> methamphetamine/uppers/speed	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> MDMA – ecstasy – “Molly”	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> hallucinogens/LSD/mushrooms	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> IV drugs of any kind - “needles”	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> Opioids <i>not</i> prescribed by <i>your</i> doctor	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____

Have you ever been **treated** for a drug 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

Psychological Care History

Have you ever been seen for **lengthy memory and cognitive testing** or examination before?

Yes: Approx. date(s) _____ **No** **Unsure**

Current Care: Are you currently receiving any mental health care? **Yes** **No**

If yes, from whom? _____ degree: _____

Past Care: 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**

Or: **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 Methadone Vivitrol Antabuse Vyvanse

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

Restoril/temazepam Ritalin Concerta Adderall Bupropion/Wellbutrin Trazodone

Others not listed above: _____

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, 1987-2023
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 Psychologist must hold a doctorate degree in psychology, complete a one-year full time internship, have at least one year of post-doctoral clinical supervision, and pass both the State and national EPPP examination. An ABPP Board Certified psychologist must in addition have several additional years post-graduate training and education in that specific specialty, and then pass national written and oral examinations in the specialty conducted by peers qualified in that 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 questions, please call Rhea at 720-587-7173. ABC Billing Service bills for us. 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 \$30.00 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 to staff from 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/billing service 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: 720-587-7173 - Fax: 720-441-0484

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 clinical practice staff, 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 if different:** _____
- 3) Other doctors, psychotherapist, etc.: _____

- 4) Hospital(s) or Other Facilities: _____
- 5) Family members or others/friends _____
- 6) Neuropsychological test data from previous cognitive 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 may have already 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.

Follow-up Review Session

Following your assessment (“testing”) session, Dr. Schneiders needs a certain amount of time to analyze your results, to integrate them with your medical information and records, 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 every day, each of whom requires such a thorough report.)

For that reason, we ask you *not* schedule follow-up review appointments with your referring doctor for **at least 3-4 weeks** specifically to discuss your neuropsychological exam there, *unless you need to see that doctor for any other medical reason*. Dr. Schneiders does his best to get a full, written analysis and report to referring doctors in about 3-4 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.]

If you did not do so when this appointment was made, to arrange a review visit, we ask that you phone the office *as soon as possible* following your examination to schedule a one-hour follow-up session for a review and discussion of your results. 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. Telehealth meetings for this purpose are sometimes also possible, though insurers now vary about covering that.

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, 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 _____