CereScan®

PATIENT:	EXAM: Quantitative Single Photon Emission Computed Tomography (qSPECT)
Name:	**If female: Are you nursing or pregnant?** ☐ Yes ☐ No
MR #:	**Handed:**
DOB:	**Date:**
Age:	**Intake Physician:** Hilary Sparrow, MA, NCC

Patient Clinical Information and History:

Primary reason(s) for getting a brain scan:

Racial/Ethnic group you identify with: _____ Height_____ Weight_____lbs.

Please check any of the following symptoms you have. Please also provide a value from 1-10 describing the intensity of each symptom (10=very severe, 1=very minor):

☐ Anger management problems_____	☐ General anxiety_____	☐ Panic attacks_____
☐ Balance problems_____	☐ Grief_____	☐ Paranoia_____
☐ Blurred or double vision_____	☐ Hallucinations_____	☐ Performance anxiety_____
☐ Cognitive decline or changes_____	☐ Hot flashes_____	☐ Personality changes_____
☐ Cognitive function problems_____	☐ Impulse control problems _____	☐ Problems paying attention_____
☐ Compulsive behavior_____	☐ Inappropriate guilt_____	☐ Problems with abstract thinking____
☐ Confusion_____	☐ Increased appetite_____	☐ Problems with language/word finding _____
☐ Decreased judgment_____	☐ Increased energy_____	☐ Promiscuity_____
☐ Delusions_____	☐ Insomnia_____	☐ Psychotic episodes_____
☐ Difficulty following instructions_____	☐ Involuntary tics/tremors_____	☐ Racing thoughts_____
☐ Difficulty integrating information_____	☐ Irritability_____	☐ Restlessness/Fidgetiness_____
☐ Difficulty learning new things_____	☐ Long-term memory problems____	☐ Ringing in ears _____
☐ Difficulty performing familiar tasks___	☐ Losing things_____	☐ Risky behavior_____
☐ Difficulty with concentration_____	☐ Loss of appetite_____	☐ Self-mutilation (cutting)_____
☐ Disorganization_____	☐ Loss of interest in things_____	☐ Sensitivity to light_____
☐ Disorientation to time and/or place____	☐ Loss of motivation_____	☐ Sensitivity to sound_____
☐ Distractibility_____	☐ Low frustration tolerance_____	☐ Sensitivity to touch_____
☐ Elevated mood_____	☐ Making careless mistakes_____	☐ Short-term memory problems_____
☐ Excessive sadness_____	☐ Mood swings_____	☐ Sleeping too much_____
☐ Fainting spells_____	☐ Muscle pain_____	☐ Social anxiety_____
☐ Fatigue_____	☐ Muscle spasms_____	☐ Suicidal thoughts_____
☐ Flashbacks of trauma_____	☐ Nausea_____	☐ Suicide attempt(s)_____
☐ Frequent dizziness_____	☐ Need less sleep _____	☐ Suicide plans_____
☐ Frequent headaches_____	☐ Nightmares_____	☐ Talkativeness_____
☐ Gastrointestinal problems_____	☐ Obsessive thoughts_____	☐ Worry_____

Diagnostic History:

Please check the boxes of any diagnoses that you have been given by a doctor or treatment provider. Please also list the date you received the diagnosis.

- ☐ ADD/ADHD _____
- ☐ Alcoholism _____
- ☐ Alzheimer's disease _____
- ☐ Anxiety _____
- ☐ Arthritis _____
- ☐ Asperger's disorder _____
- ☐ Autism _____
- ☐ Autoimmune disorder _____
- ☐ Back injuries _____
- ☐ Bipolar spectrum disorder _____
- ☐ Birth deformities _____
- ☐ Bleeding problems _____
- ☐ Blood transfusions _____
- ☐ Borderline personality disorder ____
- ☐ Brain injury _____
- ☐ Brain tumor _____
- ☐ Cancer _____
- ☐ Cerebral palsy _____
- ☐ Cholesterol abnormalities _____
- ☐ Chronic pain _____
- ☐ Conduct disorder _____
- ☐ Dementia _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Eating disorder _____
- ☐ Fatigue _____
- ☐ Fibromyalgia _____
- ☐ Headaches (migraine) _____
- ☐ Headaches (tension) _____
- ☐ Hearing problems _____
- ☐ Human immune virus (HIV) _____
- ☐ Hypertension _____
- ☐ Inhalant abuse _____
- ☐ Kidney disease _____
- ☐ Learning disorder _____
- ☐ Liver disease _____
- ☐ Lupus _____
- ☐ Lyme disease _____
- ☐ Menopause _____
- ☐ Mental retardation _____
- ☐ Multiple sclerosis _____
- ☐ Neck injury _____
- ☐ Obsessive compulsive disorder ____
- ☐ Oppositional defiant disorder ____
- ☐ Panic attacks _____
- ☐ Parkinson's disease _____
- ☐ Posttraumatic stress disorder _____
- ☐ Prescription drug abuse _____
- ☐ Schizophrenia _____
- ☐ Seizure disorder _____
- ☐ Sexually transmitted disease _____
- ☐ Sleep apnea _____
- ☐ Social phobia _____
- ☐ Stomach ulcers _____
- ☐ Stroke _____
- ☐ Substance abuse _____
- ☐ Thyroid problems _____
- ☐ Tic disorder _____
- ☐ Transient ischemic attack (TIA) ___
- ☐ Other:_____

History of Possible Brain Injury (please provide date and brief description of occurrence):

Impact injuries to the head:

1._____

☐ with head impact ☐ without head impact ☐ loss of consciousness ☐ Amnesia/disorientation ☐ post-injury confusion or headaches ☐ concussion

2. _____

☐ with head impact ☐ without head impact ☐ loss of consciousness ☐ Amnesia/disorientation ☐ post-injury confusion or headaches ☐ concussion

3. _____

☐ with head impact ☐ without head impact ☐ loss of consciousness ☐ Amnesia/disorientation ☐ post-injury confusion or headaches ☐ concussion

Motor vehicle accidents: _____

Anoxia (a sustained lack of oxygen):_____

Exposure to toxins: _____

Severe viral infection or illness: _____

Other

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Please fill out the following details about major relevant head injuries above:

MECHANISM AND DETAILS OF HEAD INJURY #1	
Mechanism of accident **PT=Post Traumatic** ☐ **PT amnesia** ☐ **Driver** ☐ **PT dizziness** ☐ **Passenger** ☐ **PT disorientation** ☐ **PT confusion** ☐ **Seatbelt** ☐ **PT headaches** ☐ **Car Totaled**	**Loss of consciousness?** ☐ **How long:**_____
Where did you hit your head?	
Last memory before accident:	
First memory after accident:	
Hospital/ER/GP	
Events at hospital:	
Diagnosed concussion?	
What symptoms developed (transient and chronic) as a result of accident?	

MECHANISM AND DETAILS OF HEAD INJURY #2	
Mechanism of accident **PT=Post Traumatic** ☐ **PT amnesia** ☐ **Driver** ☐ **PT dizziness** ☐ **Passenger** ☐ **PT disorientation** ☐ **PT confusion** ☐ **Seatbelt** ☐ **PT headaches** ☐ **Car Totaled**	**Loss of consciousness?** ☐ **How long:**_____
Where did you hit your head?	
Last memory before accident:	
First memory after accident:	
Hospital/ER/GP	
Events at hospital:	
Diagnosed concussion?	
What symptoms developed (transient and chronic) as a result of accident?	

Past Medication History

Please list **PAST** medications related to your symptoms in chronological order, if possible. Please indicate if the medication was helpful or not in relieving your symptoms under column that says "Effectiveness

Medication Name	Dose	How long did you take this medication	Effectiveness

Surgical and Hospitalization History

Please list all the major surgeries and hospitalizations you have had:

Operation/Hospitalization	Date

Family History of all major medical, neurodegenerative, or psychiatric illnesses:

None ☐

Mother: _____

Father: _____

Siblings: _____

Maternal grandmother: _____

Maternal grandfather: _____

Paternal grandmother: _____

Paternal grandfather: _____

Other blood relatives (specify):_____

Education/Employment:

Highest level of education completed: _____

Degree(s) achieved: ☐ GED ☐ H.S. diploma ☐ Trade school ☐ Associate's degree ☐ Bachelor's degree ☐ Master's degree ☐ Doctoral degree

Employment Status: ☐ FT ☐ PT ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

Trauma or Abuse History (please check any that apply):

☐ None ☐ Emotional abuse ☐ Physical abuse ☐ Sexual abuse ☐ other major traumas

Brain Imaging/Testing History

Have you had other nuclear medicine tests or procedures (example SPECT, PET Brain)? ☐ Yes ☐ No

If yes, list date and type of procedure(s):_____

Please fill in the information below if you have had any imaging/testing of your **brain or head**:

Brain Imaging Procedure:	Results	Year
MRI		
CT		
EEG		
NeuroPsych Testing		

Developmental Information:

Birth:

Adoptee: ☐Yes ☐ No **Type of birth:** ☐Vaginal ☐C-Section **Duration of birth/labor:**_____

Was there any birth trauma (i.e. umbilical cord wrapped around neck, forceps, vacuum)? ☐ Yes ☐ No

If yes, please explain_____

Childhood:

List any recurrent or severe childhood illnesses: _____

Were there any delays in your language or motor development? ☐ Yes ☐ No

If yes, please explain_____

Were you in any special education classes at school? ☐ Yes ☐ No

If yes, which grades and classes_____

Substance Use/Abuse

Alcohol Use/Abuse:

Current use of alcohol (average number of drinks per week): _____

Do you have any history of (please check all that apply):

- ☐ Alcohol abuse?
- ☐ DTs (delirium tremors)
- ☐ a seizure from alcohol withdrawl
- ☐ treatment for alcohol abuse

If yes, what kind of treatment:_____

If you are sober now, how many years of sobriety do you have? _____

Substance Use/Abuse:

Do you use recreational drugs? ☐Yes ☐No If so what is your drug of choice_____

Do you have any history of (please check all that apply):

- ☐ past recreational drug use/abuse

If yes: Name of drug(s) you abused the most _____

☐ treatment for drug abuse
If yes, what kind of treatment:_____
☐ Prescription drug use/abuse
If yes: Name of prescription drug(s) you abused the most _____

If you are clean now, how many years have you been clean for? _____

Caffeine and Nicotine:

Current caffeine consumption (per day): _____

Current tobacco consumption (per day) _____

Please fill out the table for past and current drug use/abuse (if applicable)

Drug/Alcohol	Ages Used	Frequency	Amount

Legal History (arrests, DUI, etc.): _____

Veteran History:

Have you served in the Armed Forces? If yes, what branch_____

☐ Active ☐ Retired ☐ Reserves/National Guard ☐ Discharged ☐ N/A

Have you ever been deployed to a war zone? ☐ Yes ☐ No

If yes, when and where was this? _____

Have you ever been in combat? ☐ Yes ☐ No

If yes, when and where was this? _____

Have you ever encountered any blast wave injuries ☐ Yes ☐ No

If yes, please explain_____

Goals:

What are your goals for your time at CereScan? What are you hoping to learn from your SPECT scan?

Behavioral Observations (if applicable):

Office Use:

☐Neuro ☐Forensic Location_____ Reading Physician_____