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Fax: (866) 433-3965
Email: pcc@cerescan.com
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PATIENT INFORMATION (please print)

Last Name:	**First Name:**	**M.I.:**
Phone:	**Email:**	
Mailing Address:		
City:	**State:**	**Zip:**
Date of Birth:	**Age:**	**Marital Status:**
Sex: Male ☐ Female ☐	**Weight:** lbs.	**Height:** ft. in.

If female: Are you pregnant, nursing, or is there a chance you may be pregnant? Yes ☐ No ☐

Racial/ethnic group you identify with:

RESPONSIBLE PARTY (if patient is a dependent)

Name: **Phone Number:**

EMERGENCY CONTACT (spouse, friend or relative who can be reached in case of emergency)

Full Name: **Relationship to Patient:**

Address: **Phone:**

INSURANCE INFORMATION

Insurance Carrier: **Policy Number:**

Phone Number of Insurance Carrier:

Name of Primary Insured: **DOB of Primary Insured:**

Address of Primary Insured (if different)**:**

PATIENT CLINICAL INFORMATION

Primary reason(s) for brain scan:

ALLERGIES AND ADVERSE REACTIONS TO MEDICATIONS

Allergen	Type of Adverse Reaction/Symptoms

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CURRENT MEDICATIONS AND/OR SUPPLEMENTS *Please try to use the correct spelling. If you are unsure, write "?"*

Medication/Supplement Name	Dose	Schedule	Date Started

PRIVACY & SECURITY

The Privacy Rule generally requires healthcare providers to take responsible steps to limit the use or disclosure of and request for protected health information (PHI) to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. NOTE: Uses and disclosures for the Privacy Officer may be permitted without prior consent in an emergency.

With Whom May We Share Your PHI? (Full Name)	Relationship to Patient

**If you are working with an attorney and would like us to disclose your results to them, please list their name above.*

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (if different from above):

☐ Phone: _____ ☐ Email: _____

How would you like your report delivered to you? ☐ Email ☐ Mail

I hereby authorize CereScan to release to my Referring Physician a copy of my medical records. I understand and agree that all images and medical records generated for and on my behalf will become part of CereScan's expanding proprietary database for ongoing scientific research into neurological and neurobehavioral disorders. I hereby authorize CereScan to use and replicate all medical information contained in the images and reports for proprietary research, training, teaching or other purposes deemed appropriate by CereScan. In order to protect my identity, I understand that all identifying information will be removed from all images and reports prior to its use.

Signature: _____ Name (Printed): _____ Date: _____

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SYMPTOM QUESTIONNAIRE (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 ties/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 ____

If applicable, does your suicidality involve any: ☐ Self-hate ☐ Hopelessness ☐ Agitation ☐ Psychological factors ☐ Stress

EDUCATION/EMPLOYMENT

Highest level of education completed:

☐ GED ☐ H.S. diploma ☐ Trade school ☐ Associate's degree ☐ Some college, never graduated
☐ Bachelor's degree ☐ Some graduate school, never graduated ☐ Master's degree ☐ Doctoral degree

Employment status:

☐ FT ☐ PT ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

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TRAUMA OR ABUSE HISTORY (please check any that apply)

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

DIAGNOSTIC HISTORY (please check any diagnoses that you have been given by a doctor or provider)

Please also list the date you received the diagnosis.

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

HISTORY OF BRAIN INJURY (please provide date and brief description of occurrence)

Have you experienced a head injury? ☐ Yes ☐ No

Have you experienced any of the following?

☐ Motor vehicle accidents_____

☐ Anoxia (a sustained lack of oxygen)_____

☐ Exposure to toxins_____

☐ Severe viral infection or illness_____

☐ Other:_____

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BRAIN INJURY DETAILS

HEAD INJURY #1: ☐ MVA ☐ TBI ☐ Toxic ☐ Other_____

Symptom (PT=Post Traumatic)	**How Long Did You Experience This?**
☐ PT amnesia	
☐ PT disorientation	
☐ PT headaches	
☐ PT dizziness	
☐ PT confusion	

For motor vehicle accidents:

☐ Driver ☐ Passenger
☐ Seatbelt ☐ Car totaled

Loss of consciousness? ☐ How long?_____

Briefly describe the accident:

Where did you hit your head?	
Last memory before accident	
First memory after accident	
Hospital/ER/GP	
Events at hospital	

Diagnosed concussion? ☐ Yes ☐ No **Diagnosed TBI?** ☐ Yes ☐ No

What symptoms developed (acute and chronic) as a result of the accident?

HEAD INJURY #2: ☐ MVA ☐ TBI ☐ Toxic ☐ Other_____

Symptom (PT=Post Traumatic)	**How Long Did You Experience This?**
☐ PT amnesia	
☐ PT disorientation	
☐ PT headaches	
☐ PT dizziness	
☐ PT confusion	

For motor vehicle accidents:

☐ Driver ☐ Passenger
☐ Seatbelt ☐ Car totaled

Loss of consciousness? ☐ How long?_____

Briefly describe the accident:

Where did you hit your head?	
Last memory before accident	
First memory after accident	
Hospital/ER/GP	
Events at hospital	

Diagnosed concussion? ☐ Yes ☐ No **Diagnosed TBI?** ☐ Yes ☐ No

What symptoms developed (acute and chronic) as a result of the accident?

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BRAIN INJURY DETAILS (continued)

HEAD INJURY #3: ☐ MVA ☐ TBI ☐ Toxic ☐ Other_____

Symptom (PT=Post Traumatic)	How Long Did You Experience This?
☐ PT amnesia	
☐ PT disorientation	
☐ PT headaches	
☐ PT dizziness	
☐ PT confusion	

Loss of consciousness? ☐ How long?_____

Briefly describe the accident:

For motor vehicle accidents:

☐ Driver ☐ Passenger
☐ Seatbelt ☐ Car totaled

Where did you hit your head?	
Last memory before accident	
First memory after accident	
Hospital/ER/GP	
Events at hospital	

Diagnosed concussion? ☐ Yes ☐ No **Diagnosed TBI?** ☐ Yes ☐ No

What symptoms developed (acute and chronic) as a result of the accident?

HEAD INJURY #4: ☐ MVA ☐ TBI ☐ Toxic ☐ Other_____

Symptom (PT=Post Traumatic)	How Long Did You Experience This?
☐ PT amnesia	
☐ PT disorientation	
☐ PT headaches	
☐ PT dizziness	
☐ PT confusion	

Loss of consciousness? ☐ How long?_____

Briefly describe the accident:

For motor vehicle accidents:

☐ Driver ☐ Passenger
☐ Seatbelt ☐ Car totaled

Where did you hit your head?	
Last memory before accident	
First memory after accident	
Hospital/ER/GP	
Events at hospital	

Diagnosed concussion? ☐ Yes ☐ No **Diagnosed TBI?** ☐ Yes ☐ No

What symptoms developed (acute and chronic) as a result of the accident?

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PAST MEDICATION HISTORY (please list PAST medications in chronological order, if possible)

Also, please provide a value from 1-10 describing the effectiveness of each medication)

Medication Name	Dose	How long did you take this medication?	Effectiveness

SURGICAL AND HOSPITALIZATION HISTORY (please list all major surgeries and hospitalizations)

Operation/Hospitalization	Date

FAMILY MEDICAL HISTORY (please list all major medical, neurodegenerative or psychiatric illnesses)

Mother:

Father:

Siblings:

Maternal grandmother:

Maternal grandfather:

Paternal grandmother:

Paternal grandfather:

Other blood relatives (specify):

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BRAIN IMAGING HISTORY

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

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

Brain Diagnostics	Results	Year
MRI		
CT		
EEG		
NeuroPsych Testing		

DEVELOPMENTAL INFORMATION

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:_____

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

Average number of alcoholic drinks per week:

Alcohol Abuse History (please check all that apply):

☐ Alcohol abuse

If yes, what years?_____ Average number of drinks per week:_____

☐ DTs (delirium tremors)

☐ A seizure from alcohol withdrawal

☐ Treatment for alcohol abuse

If yes, what kind of treatment:_____

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

Do you use recreational drugs? ☐ Yes ☐ No **If yes,** what is your drug of choice?_____

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SUBSTANCE USE/ABUSE (continued)

Substance Use History (please check all that apply):

- ☐ Past recreational drug use
  - **If yes,** name of drug you used the most?_____ How often?_____
- ☐ 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?_____

Current caffeine consumption (per day):

Current tobacco consumption (per day):

Legal History (arrests, DUI, etc.)_____

VETERAN HISTORY

Have you served in the Armed Forces? ☐ Yes ☐ No **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, please explain: _____

Have you ever been to combat? ☐ Yes ☐ No

If yes, please explain: _____

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?

OFFICE USE (Please do not answer the questions below this line)

☐ **Neuro** ☐ **Forensic** **Location:**_____ **Reading Physician**:_____

MR#_____ **Intake Clinician:**_____

BEHAVIORAL OBSERVATIONS (If applicable)

