

## 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 <input type="checkbox"/> Female <input type="checkbox"/>	Weight: lbs.	Height: ft. in.
If female: Are you pregnant, nursing or is there a chance you may be pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Racial/ethnic group you identify with:	Handedness: Right <input type="checkbox"/> Left <input type="checkbox"/>	

## RESPONSIBLE PARTY (if patient is a dependent)

Name:	Phone Number:
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## 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

**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 reasonable steps to limit the use or disclosure of 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 by 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<sup>®</sup> 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<sup>®</sup>'s expanding proprietary database for ongoing scientific research into neurological and neurobehavioral disorders. I hereby authorize CereScan<sup>®</sup> 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<sup>®</sup>. In order to protect my identity, I understand that all identifying information will be removed from all images and reports prior to its use.

I understand my results will be sent to me and my referring doctor, and I will have the opportunity to review my images, diagnostic findings and impressions in a follow up post imaging review session. I also understand that CereScan<sup>®</sup> is a diagnostic imaging facility and cannot provide treatment, management of care, case management services, medication protocols or prescribe medication. I further understand that CereScan<sup>®</sup> can consult with my referring provider regarding my imaging results but cannot implement a treatment plan.

Signature: \_\_\_\_\_

Name (Printed): \_\_\_\_\_

Date: \_\_\_\_\_

## 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)

<input type="checkbox"/> Anger management problems ____	<input type="checkbox"/> General anxiety ____	<input type="checkbox"/> Panic attacks ____
<input type="checkbox"/> Balance problems ____	<input type="checkbox"/> Grief ____	<input type="checkbox"/> Paranoia ____
<input type="checkbox"/> Blurred vision ____	<input type="checkbox"/> Hallucinations ____	<input type="checkbox"/> Performance anxiety ____
<input type="checkbox"/> Cognitive decline or changes ____	<input type="checkbox"/> Hot flashes ____	<input type="checkbox"/> Personality changes ____
<input type="checkbox"/> Cognitive function problems ____	<input type="checkbox"/> Impulse control problems ____	<input type="checkbox"/> Problems paying attention ____
<input type="checkbox"/> Compulsive behavior ____	<input type="checkbox"/> Inappropriate guilt ____	<input type="checkbox"/> Problems with abstract thinking ____
<input type="checkbox"/> Confusion ____	<input type="checkbox"/> Increased appetite ____	<input type="checkbox"/> Problems with language/word finding ____
<input type="checkbox"/> Decreased judgment ____	<input type="checkbox"/> Increased energy ____	<input type="checkbox"/> Promiscuity ____
<input type="checkbox"/> Delusions ____	<input type="checkbox"/> Insomnia ____	<input type="checkbox"/> Psychotic episodes ____
<input type="checkbox"/> Difficulty following instructions ____	<input type="checkbox"/> Involuntary ties/tremors ____	<input type="checkbox"/> Racing thoughts ____
<input type="checkbox"/> Difficulty integrating information ____	<input type="checkbox"/> Irritability ____	<input type="checkbox"/> Restlessness/Fidgetiness ____
<input type="checkbox"/> Difficulty learning new things ____	<input type="checkbox"/> Long-term memory problems ____	<input type="checkbox"/> Ringing in ears ____
<input type="checkbox"/> Difficulty performing familiar tasks ____	<input type="checkbox"/> Losing things ____	<input type="checkbox"/> Risky behavior ____
<input type="checkbox"/> Difficulty with concentration ____	<input type="checkbox"/> Loss of appetite ____	<input type="checkbox"/> Self-mutilation (cutting) ____
<input type="checkbox"/> Disorganization ____	<input type="checkbox"/> Loss of interest in things ____	<input type="checkbox"/> Sensitivity to light ____
<input type="checkbox"/> Disorientation to time and/or place ____	<input type="checkbox"/> Loss of motivation ____	<input type="checkbox"/> Sensitivity to sound ____
<input type="checkbox"/> Distractibility ____	<input type="checkbox"/> Low frustration tolerance ____	<input type="checkbox"/> Sensitivity to touch ____
<input type="checkbox"/> Double vision ____	<input type="checkbox"/> Making careless mistakes ____	<input type="checkbox"/> Short-term memory problems ____
<input type="checkbox"/> Elevated mood ____	<input type="checkbox"/> Mood swings ____	<input type="checkbox"/> Sleeping too much ____
<input type="checkbox"/> Excessive sadness ____	<input type="checkbox"/> Muscle pain ____	<input type="checkbox"/> Social anxiety ____
<input type="checkbox"/> Fainting spells ____	<input type="checkbox"/> Muscle spasms ____	<input type="checkbox"/> Suicidal thoughts ____
<input type="checkbox"/> Fatigue ____	<input type="checkbox"/> Nausea ____	<input type="checkbox"/> Suicide attempt(s) ____
<input type="checkbox"/> Flashbacks of trauma ____	<input type="checkbox"/> Need less sleep ____	<input type="checkbox"/> Suicide plans ____
<input type="checkbox"/> Frequent dizziness ____	<input type="checkbox"/> Nightmares ____	<input type="checkbox"/> Talkativeness ____
<input type="checkbox"/> Frequent headaches ____	<input type="checkbox"/> Obsessive thoughts ____	<input type="checkbox"/> Worry ____
<input type="checkbox"/> Gastrointestinal problems ____	<b>If applicable, does your suicidality involve any:</b> <input type="checkbox"/> Self-hate <input type="checkbox"/> Hopelessness <input type="checkbox"/> Agitation <input type="checkbox"/> Psychological factors <input type="checkbox"/> 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

### 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

## 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.

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

BRAIN INJURY DETAILS		
<b>HEAD INJURY #1:</b> <input type="checkbox"/> MVA <input type="checkbox"/> TBI <input type="checkbox"/> Toxic <input type="checkbox"/> Other _____		
<b>Symptom</b> (PT=Post Traumatic)	<b>How Long Did You Experience This?</b>	Loss of consciousness? <input type="checkbox"/> How long? _____ Date of Injury: _____
<input type="checkbox"/> PT amnesia		<b>Briefly describe the accident:</b>
<input type="checkbox"/> PT disorientation		
<input type="checkbox"/> PT headaches		
<input type="checkbox"/> PT dizziness		
<input type="checkbox"/> PT confusion		
<b>For motor vehicle accidents:</b>		
<input type="checkbox"/> Driver	<input type="checkbox"/> Passenger	
<input type="checkbox"/> Seatbelt	<input type="checkbox"/> Car totaled	
<b>Where did you hit your head?</b>		
<b>Last memory before accident</b>		
<b>First memory after accident</b>		
<b>Hospital/ER/GP</b>		
<b>Events at hospital</b>		
<b>Diagnosed concussion?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Diagnosed TBI?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>What symptoms developed (acute and chronic) as a result of the accident?</b>		
<b>HEAD INJURY #2:</b> <input type="checkbox"/> MVA <input type="checkbox"/> TBI <input type="checkbox"/> Toxic <input type="checkbox"/> Other _____		
<b>Symptom</b> (PT=Post Traumatic)	<b>How Long Did You Experience This?</b>	Loss of consciousness? <input type="checkbox"/> How long? _____ Date of Injury: _____
<input type="checkbox"/> PT amnesia		<b>Briefly describe the accident:</b>
<input type="checkbox"/> PT disorientation		
<input type="checkbox"/> PT headaches		
<input type="checkbox"/> PT dizziness		
<input type="checkbox"/> PT confusion		
<b>For motor vehicle accidents:</b>		
<input type="checkbox"/> Driver	<input type="checkbox"/> Passenger	
<input type="checkbox"/> Seatbelt	<input type="checkbox"/> Car totaled	
<b>Where did you hit your head?</b>		
<b>Last memory before accident</b>		
<b>First memory after accident</b>		
<b>Hospital/ER/GP</b>		
<b>Events at hospital</b>		
<b>Diagnosed concussion?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Diagnosed TBI?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>What symptoms developed (acute and chronic) as a result of the accident?</b>		

BRAIN INJURY DETAILS (continued)		
<b>HEAD INJURY #3:</b> <input type="checkbox"/> MVA <input type="checkbox"/> TBI <input type="checkbox"/> Toxic <input type="checkbox"/> Other _____		
<b>Symptom</b> (PT=Post Traumatic)	<b>How Long Did You Experience This?</b>	Loss of consciousness? <input type="checkbox"/> How long? _____ Date of Injury: _____
<input type="checkbox"/> PT amnesia		<b>Briefly describe the accident:</b>
<input type="checkbox"/> PT disorientation		
<input type="checkbox"/> PT headaches		
<input type="checkbox"/> PT dizziness		
<input type="checkbox"/> PT confusion		
<b>For motor vehicle accidents:</b>		
<input type="checkbox"/> Driver	<input type="checkbox"/> Passenger	
<input type="checkbox"/> Seatbelt	<input type="checkbox"/> Car totaled	
<b>Where did you hit your head?</b>		
<b>Last memory before accident</b>		
<b>First memory after accident</b>		
<b>Hospital/ER/GP</b>		
<b>Events at hospital</b>		
<b>Diagnosed concussion?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Diagnosed TBI?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>What symptoms developed (acute and chronic) as a result of the accident?</b>		
<b>HEAD INJURY #4:</b> <input type="checkbox"/> MVA <input type="checkbox"/> TBI <input type="checkbox"/> Toxic <input type="checkbox"/> Other _____		
<b>Symptom</b> (PT=Post Traumatic)	<b>How Long Did You Experience This?</b>	Loss of consciousness? <input type="checkbox"/> How long? _____ Date of Injury: _____
<input type="checkbox"/> PT amnesia		<b>Briefly describe the accident:</b>
<input type="checkbox"/> PT disorientation		
<input type="checkbox"/> PT headaches		
<input type="checkbox"/> PT dizziness		
<input type="checkbox"/> PT confusion		
<b>For motor vehicle accidents:</b>		
<input type="checkbox"/> Driver	<input type="checkbox"/> Passenger	
<input type="checkbox"/> Seatbelt	<input type="checkbox"/> Car totaled	
<b>Where did you hit your head?</b>		
<b>Last memory before accident</b>		
<b>First memory after accident</b>		
<b>Hospital/ER/GP</b>		
<b>Events at hospital</b>		
<b>Diagnosed concussion?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Diagnosed TBI?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>What symptoms developed (acute and chronic) as a result of the accident?</b>		

**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:**

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**Father:**

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**Siblings:**

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**Maternal grandmother:**

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**Maternal grandfather:**

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**Paternal grandmother:**

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**Paternal grandfather:**

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**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? \_\_\_\_\_



## 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)