CereScan®

Patient Name: _____

Date of Birth: _____

Phone: (866) 722-4806
Fax: (866) 433-3965
Email: pcc@cerescan.com
www.CereScan.com

## 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:** | | **Handedness:** Right ☐ Left ☐ |

## 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 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

**When would you like to receive your report?**

☐ Immediately upon completion ☐ At/during the imaging review session

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.

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® 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® can consult with my referring provider regarding my imaging results but cannot implement a treatment plan.

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 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 ____ |
| ☐ Double vision ____ | ☐ Making careless mistakes ____ | ☐ Short-term memory problems ____ |
| ☐ Elevated mood____ | ☐ Mood swings ____ | ☐ Sleeping too much ____ |
| ☐ Excessive sadness ____ | ☐ Muscle pain ____ | ☐ Social anxiety ____ |
| ☐ Fainting spells ____ | ☐ Muscle spasms ____ | ☐ Suicidal thoughts ____ |
| ☐ Fatigue ____ | ☐ Nausea ____ | ☐ Suicide attempt(s) ____ |
| ☐ Flashbacks of trauma ____ | ☐ Need less sleep ____ | ☐ Suicide plans ____ |
| ☐ Frequent dizziness____ | ☐ Nightmares ____ | ☐ Talkativeness ____ |
| ☐ Frequent headaches ____ | ☐ Obsessive thoughts ____ | ☐ Worry ____ |
| ☐ Gastrointestinal problems ____ | **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

**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?** | Loss of consciousness? ☐ How long?_____<br>Date of Injury: _____ |
|---|---|---|
| ☐ PT amnesia | | **Briefly describe the accident:** |
| ☐ PT disorientation | | |
| ☐ PT headaches | | |
| ☐ PT dizziness | | |
| ☐ PT confusion | | |
| **For motor vehicle accidents:**<br>☐ Driver ☐ Passenger<br>☐ 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 #2:** ☐ MVA ☐ TBI ☐ Toxic ☐ Other_____

| **Symptom** (PT=Post Traumatic) | **How Long Did You Experience This?** | Loss of consciousness? ☐ How long?_____<br>Date of Injury: _____ |
|---|---|---|
| ☐ PT amnesia | | **Briefly describe the accident:** |
| ☐ PT disorientation | | |
| ☐ PT headaches | | |
| ☐ PT dizziness | | |
| ☐ PT confusion | | |
| **For motor vehicle accidents:**<br>☐ Driver ☐ Passenger<br>☐ 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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## BRAIN INJURY DETAILS (continued)

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

| **Symptom** (PT=Post Traumatic) | **How Long Did You Experience This?** | Loss of consciousness? ☐ How long?_____<br>Date of Injury: _____ |
|---|---|---|
| ☐ PT amnesia | | **Briefly describe the accident:** |
| ☐ PT disorientation | | |
| ☐ PT headaches | | |
| ☐ PT dizziness | | |
| ☐ PT confusion | | |
| **For motor vehicle accidents:**<br>☐ Driver ☐ Passenger<br>☐ 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?** | Loss of consciousness? ☐ How long?_____<br>Date of Injury: _____ |
|---|---|---|
| ☐ PT amnesia | | **Briefly describe the accident:** |
| ☐ PT disorientation | | |
| ☐ PT headaches | | |
| ☐ PT dizziness | | |
| ☐ PT confusion | | |
| **For motor vehicle accidents:**<br>☐ Driver ☐ Passenger<br>☐ 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)