CereScan®

Patient Name: _____

Date of Birth: _____

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

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?_____ Date of Injury: _____
☐ PT amnesia		**Briefly describe the accident:**
☐ PT disorientation		
☐ PT headaches		
☐ PT dizziness		
☐ PT confusion		
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 #2: ☐ MVA ☐ TBI ☐ Toxic ☐ Other_____

Symptom (PT=Post Traumatic)	**How Long Did You Experience This?**	Loss of consciousness? ☐ How long?_____ Date of Injury: _____
☐ PT amnesia		**Briefly describe the accident:**
☐ PT disorientation		
☐ PT headaches		
☐ PT dizziness		
☐ PT confusion		
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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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?_____

Date of Injury: _____

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?	

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

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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):	

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	Name of Hospital
MRI			
CT			
EEG			
NeuroPsych Testing			

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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 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.)_____

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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?

ACKNOWLEDGMENTS

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.

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.

From time to time, CereScan® may be contracted to participate in and source subjects for research projects and clinical trials. Do you give your consent to be contacted in the future by CereScan or the company's representative regarding your willingness to participate in future research studies or trials? For detailed information, please visit the following webpage (https://cerescan.com/resources/patient-forms/) or contact CereScan at 866-722-4806**.** _____ **Initial**

_____ _____ _____

Signature: Name (Printed): Date:

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

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

MR#_____ **Intake Clinician:**_____

BEHAVIORAL OBSERVATIONS (If applicable)