Playa Vista Mental Health

Neuropsychological Evaluation

Welcome to Playa Vista Mental Health

We look forward to working with you.

Please fill out this form as best you can. Having all the facts will help us do the most thorough evaluation. If you can't remember something exactly, put an approximate answer with a question mark. Please feel free to use the backs of the pages for extended answers.

PATIENT INFORMATION

Patient name (First, Middle, Last):

____

School/Grade (If applicable):

____

IF PATIENT IS A MINOR:

Parent/Guardian 1**:**

Name (First, Last): ____

Email: ____

Phone: _______________________________ ☐ Home ☐ Work ☐ Cell

Street address: ____

City, State, Zip: ____

Parent/Guardian 2:

Name (First, Last): ____

Email: ____

Phone: _______________________________ ☐ Home ☐ Work ☐ Cell

Street address: ____

City, State, Zip: ____

Name of person completing this form: ____

Relationship to patient: ____

Please list anyone who you consulted with to complete these forms and specify their relationship to the patient:

____

____

What specific questions do you hope to have answered by this evaluation/consultation and/or treatment?

____
____
____
____
____
____

Describe any recent medical, academic, or other events that led to this assessment.

____
____
____

Please describe your/the patient's behaviors and issues of concern? What do you think may be causing the difficulties you are concerned about?

____
____
____
____
____
____

What interventions have you tried in the past to help with these areas of difficulty (e.g., tutoring, counseling, speech therapy, occupational therapy, behavior management programs, etc.)?

____
____
____

What do you consider to be your/the patient's greatest:

A. Strengths: ____

B. Challenges: ____

What school subjects are/were the easiest for you/the patient?

____

What school subjects are/were the hardest for you/the patient?

____

If currently enrolled, what are your/the patient's current grades? Please attach a copy of the last report card, if possible: ____

____

Has the patient already been given any diagnoses? Yes No

If yes, what are they? ____

By whom, and when? ____

Do/Does the patient's sibling(s) parents or other family members have a diagnosis?

Yes No

If yes, what is it/are they? ____

Has the patient already had testing/evaluations/504 Plan/IEP? If yes, what were the results and conclusions? (Please include copies of relevant reports and IEPs)

____

____

____

MEDICAL HISTORY

Primary care doctor's name and phone number: ____

____

When was the patient's last visit with their primary care provider? ______________________________

____

Please list all current medications. Specify type, dosage and condition:

____

____

Is the patient right or left handed? ____________________

When was your/the patient's last vision evaluation? ____

Does the patient wear glasses? Yes No Since what age? ____________________

Does the patient wear contacts? Yes No Since what age? ____________________

If so, does the patient wear them all of the time or only under specific circumstances (e.g., for reading):

____

When was your/the patient's last hearing exam? ____

Does the patient wear hearing aids? Yes No Since what age? ________________________________

Are there any concerns for the patient's eating habits, diet, nutrition, or growth? _____________________

____

Have you/the patient ever been in counseling or therapy? Please describe any previous counseling—reasons for treatment, length of treatment, therapist(s) name(s), types of treatments (e.g., family, individual, group therapy).

____

____

____

DEVELOPMENTAL HISTORY

If you are completing this intake form for yourself, it would be helpful to contact the person who may have the information below. If you are not able to, please answer to the best of your knowledge.

Briefly, what was the patient like to care for as an infant? _______________________________________

____

Did the patient achieve motor milestones on time? Yes No

At what age did the patient start crawling? _______________ months

First walk? ____________ months

Are there any concerns about the patient's strength and coordination? ______________________________

____

Did the patient achieve language milestones on time? Yes No

At what age did the patient say their first words? ____

What was the patient's first word? ____

At what age did the patient say their first sentence? ____

Does the patient speak clearly? Yes No

If no, what sounds are hard to say? ____

Does the patient have trouble picking up on nonverbal cues such as gestures or humor? Yes No

Please describe any other concerns regarding the patient's language development:

____

____

Does the patient get regular exercise? Yes No

If so, how often? What type? ____

____

How many hours per night does the patient sleep? _________________________________

Any other concerns? ____

FAMILY/SOCIAL HISTORY

Was the patient adopted? Yes No

If so, from where and at what age? ____

Are your/the patient's parents married, divorced, or separated? Please specify the length of time divorced or separated: ____

If the parents are not together, what is the custody agreement? _______________________

____

Information regarding biological parents:

Name/Age/Occupation of Mother: _______________________________________

Name/Age/Occupation of Father: ____

Please indicate any health problems of the parents. If deceased, please indicate age/cause of death:

____

____

____

Does the patient now or in the past share a room someone else? With whom? At what age?

____

How would you characterize your/the patient's relationship with his/her siblings? ______________

____

Describe history of childcare. If applicable, list who currently cares for the patient throughout the day:

____

____

If applicable, what is the patient's relationship like with you? ___________________________________

____

What discipline methods were found to be most effective with you/the patient? _____________________

____

Does the patient have any special talents/abilities? ____

____

What hobbies, interests, or after school activities does the patient enjoy? __________________________

____

____

Socialization history:

How well does the patient relate to others who are the same age? ________________________________

____

Has this pattern changed over time? ____

____

How well does the patient relate to others who are older? ______________________________________

____

Does the patient prefer group activities, individual activities, or both?

____

What is the patient's general mood? Are there any patterns you notice in the patient's mood?

____

____

EMERGENCY INFORMATION

In case of emergency, I give authorization for treatment by a qualified doctor or any person qualified to give emergency treatment. I release Playa Vista Mental Health from any liability for injury that may arise.

Patient Printed Name: ____

Patient Signature: ____

Date: ________________

Parent/Guardian Printed Name: ___________________________________

Parent/Guardian Signature: _______________________________________

Date: ________________

Parent/Guardian Printed Name: ___________________________________

Parent/Guardian Signature: _______________________________________

Date: ________________

Emergency contacts (if patient is a child, please list persons to contact if parents cannot be reached)

1. Name: _______________________________ Phone: _______________________
2. Name: _______________________________ Phone: _______________________

CONSENT FOR EVALUATION OF A MINOR

Sole Custody:

I, ____, have sole legal and physical custody of _______________________________________ and the sole right to make legal and medical decisions on his/her behalf. I authorize Playa Vista Mental Health to conduct an educational evaluation to gather more information about how to better meet my child's needs.

Parent/Guardian Printed Name: ___________________________________

Parent/Guardian Signature: ____

Date: ________________

Joint Custody:

We, ____________________________________ and ________________________________ have legal and physical custody of ________________________________ and the right to make legal and medical decisions on his/her behalf. We authorize Playa Vista Mental Health to conduct an educational evaluation to gather more information about how to better meet my child's needs.

Parent/Guardian Printed Name: ___________________________________

Parent/Guardian Signature: ____

Date: ________________

Parent/Guardian Printed Name: ___________________________________

Parent/Guardian Signature: ____

Date: ________________

CONSENT FOR RELEASE OF INFORMATION OF A MINOR

I/We __________________________________ and ___________________________________ authorize you to give psychoeducational information and receive educational, medical and/or psychological information, including written records and files regarding ___________________________ (child's name).

Parent/Guardian Printed Name: ___________________________________

Parent/Guardian Signature: ____

Date: ________________

Parent/Guardian Printed Name: ___________________________________

Parent/Guardian Signature: ____

Date: ________________

TERMS AND CONDITIONS

In order to conduct an evaluation, all forms must be completed in full and signed in the appropriate places.

I/We acknowledge that no warranty or guarantee, expressed or implied, is made as to any patient's success or performance on any test or in any other procedure or process designated to assess intelligence, knowledge and/or academic abilities and hereby waive any such warranty or guarantee. Patient's parents and/or legal guardians further acknowledge that a patient's failure to perform on any test or in any other procedure or process designed to assess a patient's intelligence, knowledge and/or academic abilities at the level expected shall not constitute a breach of this contract nor any other legal cognizable cause of action against Playa Vista Mental Health, its officers, employees or independent contractors. Patient's parents and/or legal guardians hereby release and discharge Playa Vista Mental Health from any and all liability for injury and/or damages allegedly arising out of a patient's failure to perform at any defined level on any such test or other procedure or process designed to assess a patient's intelligence, knowledge, and/or academic abilities.

In signing this agreement, it is understood that I agree to the terms and conditions of this document and are undertaking the full and legal financial responsibility for promptly paying the designated fees. It is understood that if more than one person signs this agreement our obligation under its terms is joint and several. I agree to inform Playa Vista Mental Health immediately of any changes in legal custody and to respond promptly to all communications from Playa Vista Mental Health.

Patient Printed Name: ____

Patient Signature: ____

Date: ______________

Parent/Legal Guardian Printed Name: __________________________________

Parent/Legal Guardian Signature: _____________________________________

Date: ______________

Parent/Legal Guardian Printed Name: __________________________________

Parent/Legal Guardian Signature: _____________________________________

Date: ______________