Assess Texas
Sharna Wood, PhD
800-650-4990

190 North Ridgeway, Suite 101
Cleburne, TX 76033

434 E Loop 281, Suite 300
Longview, TX 75605

Today's evaluation is for: DARS/DDS ❑ Neuropsychological ❑ Other:				
Place Tested:			Today's date:	
Person Completing Form (if not the examinee):				
How are you related to the examinee?				
EXAMINEE INFORMATION				
Patient's Last name	First	Middle	Birthdate	Age
SSN:	Email Address:			
Gender: ❑ M ❑ F Right handed ❑ Left handed ❑	Caucasian (White) ❑ Hispanic ❑ African American ❑ Other ❑:		Never Married ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Living Together ❑	
Street Address	City		State and Zip	
Phone: ( )			Cell: ( )	
Emergency contact:			Phone: ( )	

Medications

Please list all medications you are currently taking, along with information regarding what disorder they are prescribed to treat, the dosage, and when you take them.
Please include all over-the-counter, herbal, and "nontraditional" medicines.

Name of medicine	Taken for?	Dosage	When/How often?

What side effects do you experience from your medications (if any)?

Survey of Daily Activities

Instructions: Please place a check mark under the column that best describes your ability to perform the following tasks (only one check per task, please):

	Completely unable to perform task *(I can't do this at all.)*	Requires assistance and/or supervision *(I need help to do this.)*	Has difficulty but accomplishes task or has never done but the patient feels could do with difficulty *(This is hard for me, but I can do it.)*	Normal performance or has never done task but the patient could do the task if necessary *(I can do this with no trouble.)*
Writing checks, paying bills, balancing a checkbook.				
Assembling tax records, business affairs or papers.				
Shopping alone for clothes, household needs or groceries.				
Using the telephone.				
Playing a game of skill, working on a hobby.				
Heating water, making a cup of coffee, turning off the stove.				
Preparing a balanced meal.				
Keeping track of current events.				
Engaging in sexual activity.				
Paying attention to, understanding, discussing a TV show, book or magazine.				
Remembering appointments, family occasions, holidays, medications.				
Mailing a letter.				
Traveling out of the neighborhood, driving, arranging to take buses or cabs.				
Dress, bathe and care for personal hygiene.				
Household chores such as cleaning and laundry.				
Outdoor chores such as yard work.				

Additional Information

If there is anything else that you think is important for us to include in your report to help decide on appropriate action for your case, please include it in the space below.

Thank you for completing this form.

INFORMED CONSENT

This evaluation by Sharna L. Wood, Ph.D. (Assess Texas) is being conducted at the request of your physician, your attorney, Physician Life Care Planning (PLCP), or the Texas Division for Assistive and Rehabilitative Services (DARS/DDS) and is therefore different from other psychological or neuropsychological services that you may have received in the past. It is important for you to understand how this evaluation differs from more traditional psychological or neuropsychological evaluation.

While the results of this evaluation may or may not be helpful to you personally, the goal is to provide information about how you are functioning psychologically and/or neuropsychologically to the individual or agency requesting the evaluation. In most cases, this evaluation is intended for use in some type of a legal proceeding. As such, the confidentiality of the evaluation and the results is determined by the rules of that legal system. If someone other than you (such as DARS/DDS, your attorney, or a judge) has requested this evaluation, that person or entity will receive a copy of my report and will control how it is to be used and who has access to it.

Typically, the results of this evaluation are protected by the attorney-client privilege. Exceptions to this might include a determination on my part that you are dangerous to yourself or another person or if you reveal information that a minor, elder, or disabled person has been abused. I am also required to release this information if a court orders me to do so. There may be other examples where the laws require me to release the information obtained during the evaluation. We will discuss these situations on a case-by-case basis.

Once a decision has been made to use the report in a legal proceeding, the report and any information pertaining to it will probably be admissible into evidence along with any other information that was provided concerning your mental health and functioning. If you have any concerns about the use or distribution of my report, you should discuss these issues carefully with your attorney.

If someone other than you requested the evaluation, that individual or entity is my client and has authority over the results, including whether or not any information will be released to you or to anyone else. In addition, because the evaluation was requested by another party, and is not for the purpose of treatment, the confidentiality has fewer legal protections. I will not release the information unless instructed to do so by the person or entity that hired me or in situations when I am legally required to do so, such as court orders.

Your participation in this evaluation is voluntary. I will not conduct the evaluation without your signature on this document. You also have the right to stop the evaluation at any time. There may be legal consequences if you stop the evaluation; therefore, it would be in your best interest to consult with your attorney before doing so. In addition, if appointments are not kept or are cancelled within 24 hours of the appointment time, either you or the person or entity requesting the evaluation will incur charges for the unused time that has been reserved for these services.

The evaluation itself consists of two separate parts: an interview and psychological and/or neuropsychological testing. In addition, it may be necessary for me to review other materials related to your case such as court records, depositions, transcripts, medical records, et cetera.

If, at any time, you have a question about any aspect of the evaluation or these procedures, please feel free to ask me. In addition, if at any time you need a break from the evaluation, please let me know and we will stop and take a short break. Once the evaluation is completed, and with the permission of the requesting party, I may be able to have a meeting with you to explain the results and answer any questions you might have.

I have read and agree to the above: _____

Date: _____

INFORMED CONSENT
Sign, date, and keep

This evaluation by Sharna L. Wood, Ph.D. (Assess Texas) is being conducted at the request of your physician, your attorney, Physician Life Care Planning (PLCP), or the Texas Division for Assistive and Rehabilitative Services (DARS/DDS) and is therefore different from other psychological/neuropsychological services that you may have received in the past. It is important for you to understand how this evaluation differs from more traditional psychological or neuropsychological evaluation.

While the results of this evaluation may or may not be helpful to you personally, the goal is to provide information about how you are functioning psychologically and/or neuropsychologically to the individual or agency requesting the evaluation. In most cases, this evaluation is intended for use in some type of a legal proceeding. As such, the confidentiality of the evaluation and the results is determined by the rules of that legal system. If someone other than yourself (such as DARS/DDS, your attorney, or a judge) has requested this evaluation, he/she/they will receive a copy of my report and will control how it is to be used and who has access to it.

Typically, the results of this evaluation are protected by the attorney-client privilege.
Exceptions to this might include a determination on my part that you are dangerous to another person or if you reveal information that a minor, elder, or disabled person has been abused. I am also required to release this information if a court orders me to do so. There may be other examples where the laws require me to release the information obtained during the evaluation. We will discuss these situations on a case-by-case basis.

Once a decision has been made to use the report in a legal proceeding, the report and any information pertaining to it will probably be admissible into evidence along with any other information that was provided concerning your mental health and functioning. If you have any concerns about the use or distribution of my report, you should discuss these issues carefully with your attorney.

If someone other than you requested the evaluation, that individual or entity is my client and has authority over the results, including whether or not any information will be released to you or to anyone else. In addition, because the evaluation was requested by another party, and is not for the purpose of treatment or counseling, the confidentiality has fewer legal protections. I will not release the information unless instructed to do so by the person or entity that hired me or in situations when I am legally required to do so, such as court orders.

Your participation in this evaluation is voluntary. I will not conduct the evaluation without your signature on this document. You also have the right to stop the evaluation at any time. There may be legal consequences if you stop the evaluation; therefore, it would be in your best interest to consult with your attorney before doing so. In addition, if appointments are not kept or are cancelled within 24 hours of the appointment time, the person or entity requesting the evaluation will incur charges for the unused time that has been reserved for these services.

The evaluation itself consists of two separate parts: an interview and psychological and/or neuropsychological testing. In addition, it may be necessary for me to review other materials related to your case such as court records, depositions, transcripts, medical records, et cetera.

If, at any time, you have a question about any aspect of the evaluation or these procedures, please feel free to ask me. In addition, if at any time you need a break from the evaluation, please let me know and we will take a short break. Once the evaluation is completed, and with the permission of the requesting party, I may be able to have a meeting with you to explain the results and answer any questions you might have.

I have read and agree to the above: _____

Date: _____

Neuropsychological Symptoms Questionnaire

Answer <u>every question</u> completely.

Examinee Information

Person Completing Form: (if not the examinee)			Today's date: / /	
How are you related to the examinee?				
Patient's Last name	First	Middle	Birthdate / /	Age

Neuropsychological Symptoms

Have there been any changes in your sleep patterns in the last year?			Yes ❑ No ❑
If yes, what were they?			
Have you gained or lost weight without changing your eating habits?			Yes ❑ No ❑
If yes, how much weight have you gained❑ or lost❑?			
Have you had headaches?			
If you have had headaches, at what time of day?			
Right side ❑ Left side ❑ Both ❑		Starting in back ❑ Starting in front ❑	
What makes your headaches better?			
What makes your headaches worse?			

How much alcohol do you drink each day? (# drinks or beers)			
How many cigarettes do you smoke each day?			
Have you had dizzy spells lately?			Yes ❑ No ❑
If yes, what caused your dizzy spells?			
Have you passed out?	Yes ❑ No ❑	If yes, why?	

Have you had changes in the way you walk?	Yes ❑ No ❑
If yes, how has your walk changed?	
Have you had any changes in your vision?	Yes ❑ No ❑
If yes, how has your vision changed?	
Lately, have things dropped out of your hands?	Yes ❑ No ❑

Do you sometimes not understand things you read?		Yes ❑ No ❑
Do your hands tremble sometimes?		Yes ❑ No ❑
All the time?		Yes ❑ No ❑
Do other parts of your body tremble sometimes?		Yes ❑ No ❑
Which ones?		
All the time? Has your sense of direction changed?		Yes ❑ No ❑ Yes ❑ No ❑
Have you hit your head lately?		Yes ❑ No ❑
If yes, please explain:		
Has your memory changed?		Yes ❑ No ❑
If yes, please explain:		
Sometimes, when people talk to you, do they seem to mumble? Do you slur your words, sometimes?		Yes ❑ No ❑ Yes ❑ No ❑
If yes, when?		
Sometimes, have you started to say something and then forgotten what it was?		Yes ❑ No ❑
Do you sometimes find it difficult to remember the names of common things (car, watch, spoon, etc.)?		Yes ❑ No ❑
Do you have epilepsy?		Yes ❑ No ❑
Has anyone in your family had epilepsy?	Yes ❑ No ❑	If yes, who?
Is there any spot on your head that hurts when touched?		Yes ❑ No ❑
Sometimes, does a muscle start jumping or twitching?		Yes ❑ No ❑
Have you ever experienced temporary blindness in one or both eyes?		Yes ❑ No ❑
Sometimes do you hear or see things that others don't?		Yes ❑ No ❑
If yes, what?		
Have you recently lost control of your bowels or bladder?		Yes ❑ No ❑
Are you left handed?		Yes ❑ No ❑
Have you always been left handed?		Yes ❑ No ❑
If no, what happened?		

Do you often feel worried or anxious?		Yes ❑ No ❑
If yes, about what?		
Lately, have you had a feeling that you have been in a place or situation before, even though you know you haven't?		Yes ❑ No ❑
Has your handwriting changed recently?		Yes ❑ No ❑
Sometimes do you experience strong smells when nobody else does?		Yes ❑ No ❑
If yes, what?		
Has your sense of smell changed recently?	Yes ❑ No ❑	increased ❑ decreased ❑
Lately have you started drinking more water than you usually do?		Yes ❑ No ❑
Has the way you talk changed?		Yes ❑ No ❑
If yes, how?		
Do you lose your balance easily?		Yes ❑ No ❑
Does any part of your body frequently hurt?		Yes ❑ No ❑
If yes, which one(s)?		
Have you been in an accident?		Yes ❑ No ❑
If yes, what happened?		
Who is your physician?		
When did you last have a complete physical?		
Have their been any changes in your sexual responsiveness?		Yes ❑ No ❑
If yes, what has changed?		
Does any part of your body feel numb?		Yes ❑ No ❑
If yes, which one(s)?		
Do you come in contact with any chemicals in your work?		Yes ❑ No ❑
If yes, which one(s)?		
What animals do you come in contact with?		
Have you ever had syphilis?		Yes ❑ No ❑
If yes, when did you have it treated?		

Do either of your eyelids seem to droop a little more than before?	Yes ❑ No ❑
If yes, which one?	
Recently, have you had a thought that went on and on in your mind, and you couldn't stop it?	Yes ❑ No ❑
Has anyone in your family had a neurological disease?	Yes ❑ No ❑
Recently, have you reached for something and your hand missed it?	Yes ❑ No ❑
Have people's attitudes towards you seem to have changed?	Yes ❑ No ❑
If yes, how?	
Can you move your head as well as usual?	Yes ❑ No ❑
If no, please explain.	
When and what was your last illness?	
Is there often a ringing or buzzing in your ears?	Yes ❑ No ❑
Have you noticed a change in the way things taste to you?	Yes ❑ No ❑
If yes, please explain.	
Do you snore?	Yes ❑ No ❑

Neurocognitive Symptoms Checklist

Sensory Symptoms

How often have you smelled things which other people can't smell, such as feces, urine, body odor or smoke?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Olfactory disturbances
How often have you seen things in your peripheral vision such as stars, bugs, worms, or threads?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Visual Disturbances
How often have you seen mice or cockroaches run across the floor, but when you turn to look, you don't see them?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Visual Disturbances
How often have you felt as though bugs are crawling on you, or that something is brushing up against your skin, such as a cobweb?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Haptic Disturbances
How often have you gone numb in a part of your body for no apparent reason?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Anesthesias

How often have you gotten a ringing, buzzing, rushing, or tapping in your ears which comes and goes for no reason?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Auditory Disturbances
How often have you answered the telephone only to find that it had not actually been ringing?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Auditory Disturbances
How often have you gotten severe headaches that are so bad that you became nauseated or wanted to throw up?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Sick Headaches
How often have you gotten a pain in your head which you would not classify as a headache?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Head Pains
How often have you had a marked urinary urgency, but failed to produce any urine when going to the bathroom?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Urinary Urgency
How often have objects appeared to be much smaller or much farther away from you than they really are?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Micropsia
How often have objects appeared to be much larger or much closer to you than they actually are?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Macropsia

How often have you become dizzy for no apparent reason?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Dizziness
How often has the room seemed as if it is spinning for no particular reason?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Vertigo
How often have you smelled things which other people can't smell, such as feces, urine, body odor or smoke?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Olfactory Disturbances
How often have you felt like your stomach or internal organs are rising up into your chest?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Epigastric Sensation

Cognitive Symptoms

How often have you had trouble with the pronunciation of words with the effect that you appear a bit intoxicated even though you haven't been drinking?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Speech Articulation
How often have you suddenly had trouble thinking of words you should know and were able to say moments before?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Word Finding
How often have you uttered a sentence that doesn't make any sense and involves words other than those you wished to say?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Confused Speech

How often have you become quite suddenly and intensely confused or perplexed and then have the feeling pass in a few minutes?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Confusion
How often have you had an overwhelming feeling that things are weird, strange, or wrong, sort of like entering the twilight zone?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Jamais Vu
How often have you felt that familiar places or persons are somehow not familiar or the way they should be?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Jamais Vu
How often have you gotten the feeling that you have experienced something or been someplace before, even though you know you have not?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Déja Vu
How often have you had clear cut gaps in your memory during which you cannot remember anything over a period of 5 minutes?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Memory Gaps
How often have you found that you have missed major sections of TV shows you have been watching, like someone has spliced out a section of a movie?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Memory Gaps
How often have you found yourself driving or walking without remembering how you got there or where you were going?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Automatisms

How often have people told you about things you have said or done for which you have no memory at all?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Automatisms
How often have you had staring spells where you become sort of hypnotized by a bright or shiny object?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Staring Spells
How often have people told you that there are times when you are staring and have a blank look on your face?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Staring Spells
How often have you felt that your memory or concentration is getting substantially worse every year?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Mental Decline
How often have you lost consciousness or just blacked out?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Loss of Consciousness

Affective Symptoms

How often have you been so depressed that you think seriously about suicide?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Depression with Suicidal Ideation
How often have you become abruptly more depressed than you were a few minutes or seconds earlier with no apparent reason?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Sudden Depression

How often have you been inclined to panic or become very anxious for no reason?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Anxiety
How often have you become extremely and intensely angry for no reason?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Unprovoked Anger
How often have people told you that you become very angry and you do not remember?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Anger Outburst

Nocturnal Phenomena

How often have you walked or talked in your sleep so that you are capable of interacting with people (even incoherently), performing complex activity (possibly odd), or are able to do things that are complex or purposeful that another person would think you are awake?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Parasomnias
How often have you felt an irresistible urge to sleep during the day, and then sleep so soundly that no one can arouse you?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Uncontrollable Sleeping Spells
How often have you awakened to realize that you have been sweating so much that the bed sheets are soaked?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Thermo-regulatory Dysfunction
How often have you had vivid nightmares followed by abrupt awakening and insomnia lasting at least one hour?	❑ 0) never in the last year ❑ 1) 2 or 3 times in the past year ❑ 2) at least once a month ❑ 3) at least once a week ❑ 4) several times a week ❑ 5) every day	Nightmares and Nocturnal Insomnia