



## 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>(I can't do this at all.)</i>	Requires assistance and/or supervision  <i>(I need help to do this.)</i>	Has difficulty but accomplishes task or has never done but the patient feels could do with difficulty  <i>(This is hard for me, but I can do it.)</i>	Normal performance or has never done task but the patient could do the task if necessary  <i>(I can do this with no trouble.)</i>
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.				

## Neuropsychological Symptoms

Have there been any changes in your sleep patterns in the last year?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, what were they?	
Do you observe a regular bedtime/wake time?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you snore?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you using a CPAP/BIPAP machine?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you gained or lost weight without changing your eating habits?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, how much weight have you gained or lost?	
Have you had headaches?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Right side <input type="checkbox"/> Left side <input type="checkbox"/> Both <input type="checkbox"/> Starting in back <input type="checkbox"/> Starting in front <input type="checkbox"/>	
If you have had headaches, what triggers them?	
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?	
Do you use marijuana or recreational drugs?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, which ones do you use?	
Have you had dizzy spells lately?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, what caused your dizzy spells?	
Have you passed out?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, why?	

Have you had changes in the way you walk?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, how has your walk changed?	
Have you had any changes in your vision?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have things dropped out of your hands?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Do you sometimes not understand things you read?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Do your hands tremble?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, how often and when?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Do other parts of your body tremble sometimes?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Which ones?		
All the time?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Has your sense of direction changed?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever been diagnosed with a concussion or TBI?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please explain:		
Has your memory changed?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please explain:		
Sometimes, when people talk to you, do they seem to mumble?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have seizures?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Has anyone in your family had epilepsy?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, who?
Is there any spot on your head that hurts when touched?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Sometimes, does a muscle start jumping or twitching?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever experienced temporary blindness in one or both eyes?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Sometimes do you hear or see things that others don't?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, what?		
Have you recently lost control of your bowels or bladder?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Has your handwriting changed recently?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you left handed?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you always been left handed?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If no, what happened?		
Do you often feel worried or anxious?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, about what?		

Has your sense of smell changed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	increased <input type="checkbox"/> decreased <input type="checkbox"/>
Has your sense of taste changed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	increased <input type="checkbox"/> decreased <input type="checkbox"/>
Lately have you started drinking more water than you usually do?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Has the way you talk changed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, how?		
Do you lose your balance easily?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does any part of your body frequently hurt?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, which one(s)?		
Have you been in an accident?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, what happened?		
Who is your physician?		
When did you last have a complete physical?		
Has there been any change in your sexual responsiveness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, what has changed?		
Does any part of your body feel numb?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, which one(s)?		
Do you come in contact with any chemicals in your work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, which one(s)?		
What animals do you come in contact with?		
Have you ever had syphilis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, when did you have it treated?		
Do either of your eyelids seem to droop a little more than before?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
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 <input type="checkbox"/> No <input type="checkbox"/>	
Has anyone in your family had a neurological disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Recently, have you reached for something and your hand missed it?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have people's attitudes towards you seem to have changed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

If yes, how?	
Can you move your head as well as usual?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If no, please explain.	
When and what was your last illness?	
Is there often a ringing or buzzing in your ears?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please explain.	

<b>Sensory Symptoms</b>		
How often have you smelled strong odors that other people don't smell, such as feces, urine, or smoke?  ( <i>Olfactory Disturbance</i> )	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
	<input type="checkbox"/> 5) every day	
How often have you seen things in your peripheral vision such as stars, bugs, worms, or threads?  ( <i>Visual Disturbance</i> )	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
	<input type="checkbox"/> 5) every day	
How often have you seen mice or cockroaches run across the floor, but when you turn to look, you don't see them?  ( <i>Visual Disturbance</i> )	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
	<input type="checkbox"/> 5) every day	
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?  ( <i>Haptic Disturbance</i> )	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
	<input type="checkbox"/> 5) every day	
How often have you gone numb in a part of your body for no apparent reason?  ( <i>Anesthesias</i> )	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
	<input type="checkbox"/> 5) every day	

How often have you gotten a ringing, buzzing, rushing, or tapping in your ears which comes and goes for no reason?  (Auditory Disturbance)	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
	<input type="checkbox"/> 5) every day	
How often have you answered the phone only to find that it had not actually been ringing?  (Auditory Disturbance)	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
	<input type="checkbox"/> 5) every day	
How often have you gotten severe headaches that are so bad that you became nauseated or wanted to throw up?  (Sick Headaches)	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
	<input type="checkbox"/> 5) every day	
How often have you gotten a pain in your head that you would not classify as a headache?  (Head Pains)	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
	<input type="checkbox"/> 5) every day	
How often have you had urinary urgency but did not produce any urine when going to the bathroom?  (Urinary Urgency)	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
	<input type="checkbox"/> 5) every day	
How often have objects appeared to be much smaller or much farther away from you than they really are?  (Micropsia)	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
	<input type="checkbox"/> 5) every day	
How often have objects appeared to be much larger or much closer to you than they actually are?  (Macropsia)	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
	<input type="checkbox"/> 5) every day	

How often have you become dizzy for no apparent reason?  ( <i>Dizziness</i> )	<input type="checkbox"/> 0) never in the last year <input type="checkbox"/> 1) 2 or 3 times in the past year <input type="checkbox"/> 2) at least once a month <input type="checkbox"/> 3) at least once a week <input type="checkbox"/> 4) several times a week <input type="checkbox"/> 5) every day	About when did this start?  0-10 how much does this bother you on most days?
How often has the room seemed as if it was spinning for no particular reason?  ( <i>Vertigo</i> )	<input type="checkbox"/> 0) never in the last year <input type="checkbox"/> 1) 2 or 3 times in the past year <input type="checkbox"/> 2) at least once a month <input type="checkbox"/> 3) at least once a week <input type="checkbox"/> 4) several times a week <input type="checkbox"/> 5) every day	About when did this start?  0-10 how much does this bother you on most days?
How often have you felt like your stomach or internal organs are rising up into your chest?  ( <i>Epigastric Sensation</i> )	<input type="checkbox"/> 0) never in the last year <input type="checkbox"/> 1) 2 or 3 times in the past year <input type="checkbox"/> 2) at least once a month <input type="checkbox"/> 3) at least once a week <input type="checkbox"/> 4) several times a week <input type="checkbox"/> 5) every day	About when did this start?  0-10 how much does this bother you on most days?
Anything else? Explain.	<input type="checkbox"/> 0) never in the last year <input type="checkbox"/> 1) 2 or 3 times in the past year <input type="checkbox"/> 2) at least once a month <input type="checkbox"/> 3) at least once a week <input type="checkbox"/> 4) several times a week <input type="checkbox"/> 5) every day	About when did this start?  0-10 how much does this bother you on most days?
<b>Cognitive Symptoms</b>		
How often have you had trouble pronouncing words with the effect that you appear to be a bit intoxicated even though you haven't been drinking?  ( <i>Speech Articulation</i> )	<input type="checkbox"/> 0) never in the last year <input type="checkbox"/> 1) 2 or 3 times in the past year <input type="checkbox"/> 2) at least once a month <input type="checkbox"/> 3) at least once a week <input type="checkbox"/> 4) several times a week <input type="checkbox"/> 5) every day	About when did this start?  0-10 how much does this bother you on most days?
How often have you suddenly had trouble thinking of words you should know and were able to say moments before?  ( <i>Word Finding</i> )	<input type="checkbox"/> 0) never in the last year <input type="checkbox"/> 1) 2 or 3 times in the past year <input type="checkbox"/> 2) at least once a month <input type="checkbox"/> 3) at least once a week <input type="checkbox"/> 4) several times a week <input type="checkbox"/> 5) every day	About when did this start?  0-10 how much does this bother you on most days?

<p>How often have you uttered a sentence that doesn't make sense and involves words other than those you wished to say?</p> <p><i>(Confused Speech)</i></p>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
<p>How often have you become quite suddenly and intensely confused and then have the feeling pass in a few minutes?</p> <p><i>(Confusion)</i></p>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
<p>How often have you had an overwhelming feeling that things are weird, strange or wrong, like you've entered the Twilight Zone?</p> <p><i>(Jamais Vu)</i></p>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
<p>How often have you felt that familiar places or people are somehow not familiar or the way they should be?</p> <p><i>(Jamais Vu)</i></p>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
<p>How often have you felt that you have experienced something or been someplace before, even though you know you haven't?</p> <p><i>(Déjà Vu)</i></p>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
<p>How often have you had clear cut gaps in your memory during which you cannot remember anything over a period of 5 minutes or more?</p> <p><i>(Memory Gaps)</i></p>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
<p>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 the program?</p> <p><i>(Memory Gaps)</i></p>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		

How often have you found yourself driving or walking without remembering how you got there or where you were going?  <i>(Automatisms)</i>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
How often have people told you about things you have said or done for which you have no memory at all?  <i>(Automatisms)</i>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
How often have you had staring spells where you become sort of hypnotized by a bright or shiny object?  <i>(Staring Spells)</i>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
How often have you felt that your memory or concentration is getting substantially worse every year?  <i>(Mental Decline)</i>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
How often have you lost consciousness or just blacked out?  <i>(Loss of Consciousness)</i>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
Anything else? Explain.	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
<b>Affective Symptoms</b>		
How often have you been so depressed that you think seriously about suicide?  <i>(Depression with Suicidal Ideation)</i>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		

How often have you become abruptly more depressed than you were moments ago for no apparent reason?  <i>(Sudden Depression)</i>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
How often have you been inclined to panic or become very anxious for no apparent reason?  <i>(Anxiety)</i>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
How often have you become extremely and intensely angry for no apparent reason?  <i>(Unprovoked Anger)</i>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
How often have people told you that you become very angry, yet you do not remember?  <i>(Anger Outbursts)</i>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
Anything else? Explain.	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
<b>Nocturnal Phenomena</b>		
How often have you walked or talked in your sleep and appeared capable of interacting with people (even incoherently), performing complex, possibly odd activities, or are able to do things that are complex or purposeful that another person would think you are awake?  <i>(Parasomnias)</i>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		

How often have you felt an irresistible urge to sleep during the day, then sleep so soundly that no one can wake you?  <i>(Uncontrollable Sleeping Spells)</i>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
How often have you been awakened to realize that you have been sweating so much that the bed sheets are soaked?  <i>(Thermoregulatory Dysfunction)</i>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
How often have you had vivid nightmares followed by abrupt awakening and insomnia lasting at least one hour?  <i>(Nightmares and Nocturnal Insomnia)</i>	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		
Anything else? Explain.	<input type="checkbox"/> 0) never in the last year	About when did this start?
	<input type="checkbox"/> 1) 2 or 3 times in the past year	
	<input type="checkbox"/> 2) at least once a month	0-10 how much does this bother you on most days?
	<input type="checkbox"/> 3) at least once a week	
	<input type="checkbox"/> 4) several times a week	
<input type="checkbox"/> 5) every day		

Additional Information


Thank you for completing this form.

## INFORMED CONSENT

### Sign, Date, and Return

This evaluation by Sharna L. Wood, Ph.D. (Assess Texas) is being conducted at the request of the Texas Workforce Commission, Texas Social Security Disability Determination Services, or at the request of attorney or insurance company in regard to a legal proceeding in which you are a party. Therefore, it is different from other psychological or neuropsychological services that you may have undergone 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 those 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 are determined by the rules of the legal system. If someone other than you (such as TWC/DDS, an insurance company, an 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. You should discuss these situations with your attorney.

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, there are fewer legal protections regarding confidentiality, but I will not release the information to an outside party 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 consent. 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. I am not a treating doctor, so you will not be returning to me for any type of therapy or treatment, although if I think you would benefit from treatment, I will recommend it in my report.

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.

I have read and understand the above: \_\_\_\_\_

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

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