Assess Texas, PLLC
Sharna L. Wood, Ph.D.
501 N. Main Street, Suite A
Cleburne, TX 76033
800-650-4990

Test date:		Today's evaluation is for:		
Place Tested:		Referred by:		
Person Completing Form (if not the examinee):				
How are you related to the examinee?				
EXAMINEE INFORMATION				
Name of Child			Birthdate	Age
Address		City	State and Zip	
Phone:		Emergency Contact:		
SSN:		Email Address:		
Gender: □ M □ F □Other:	Race/Ethnicity: African American □ Caucasian (White) □ Hispanic □ Other :	# years education:	Parents' Educational Level	
Right handed □ Left handed □ Ambidextrous □			Mother	Father

Medications

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

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

What side effects does your child experience from their medications (if any)?

Neuropsychological Symptoms

Have there been any changes in your child's sleep patterns in the last year?	Yes □ No□
If yes, what were they?	
Does your child observe a regular bedtime/wake time?	Yes □ No □
Does your child snore?	Yes □ No □
Does your child use a CPAP/BIPAP machine?	Yes □ No □
Has your child gained or lost weight without changing their eating habits?	Yes □ No
If yes, how much weight has your child gained or lost?	
Does your child complain of headaches?	Yes □ No □
Right side □ Left side □ Both □ Starting in back □ Starting in front □	
If your child has had headaches, what triggers them?	
What makes your child's headaches better?	
What makes your child's headaches worse?	

Has your child exhibited behavioral problems lately?	Yes □ No □
If yes, please explain:	
Do your child use marijuana or recreational drugs?	Yes □ No □
If yes, which ones do your child use?	
Have your child had dizzy spells lately?	Yes □ No □
If yes, what caused your child's dizzy spells?	
Have your child passed out?	Yes □ No □
If yes, why?	

Has your child had changes in the way they walk?	Yes □ No □
If yes, how has your child's walk changed?	
Have there been any changes in your child's vision?	Yes □ No □
Have things dropped out of your child's hands?	Yes □ No □

Do your child sometimes not understand things they read?	Yes □ No □
Do your child's hands tremble?	Yes □ No □
If yes, how often and when?	Yes □ No □
Do other parts of your child's body tremble sometimes?	Yes □ No □
Which ones?	
All the time?	Yes □ No □
Has your child's sense of direction changed?	Yes □ No □
Has your child ever been diagnosed with a concussion or TBI?	Yes □ No □
If yes, please explain:	
Has your child's memory changed?	Yes □ No □
If yes, please explain:	
Does your child have seizures?	Yes □ No □
Has anyone in your family had epilepsy? Yes □ No □	If yes, who?
Is there any spot on your child's head that hurts when touched?	Yes □ No □
Does your child experience muscle twitches?	Yes □ No □
Has your child ever experienced temporary blindness in one or both eyes?	Yes □ No □
Sometimes does your child appear to hear or see things that others don't?	Yes □ No □
If yes, what?	
Has your child recently lost control of their bowels or bladder?	Yes □ No □
Has your child's handwriting changed recently?	Yes □ No □
Is your child left handed?	Yes □ No □
Does your child have developmental delays?	Yes □ No □
If yes, in what area(s)?	
Does your child often feel worried or anxious?	Yes □ No □
If yes, about what?	

Has your child's sense of smell changed?	Yes □ No □	increased □	decreased □
Has your child's sense of taste changed?	Yes □ No □	increased □	decreased □
Lately has your child started drinking more water than normal?			Yes □ No □
Has the way your child talk changed?			Yes □ No □
If yes, how?			
Do your child lose their balance easily?			Yes □ No □
Does your child complain of body pains?			Yes □ No □
If yes, please explain.			
Has your child been in an accident?			Yes □ No □
If yes, what happened?			
Who is your child's physician?			
When did your child last have a complete physical?			
If yes, has anything changed?			
Does your child complain of numbness?			Yes □ No □
Does your child receive special education services?			Yes □ No □
If yes, which one(s)?			
Does your child have a disability?			Yes □ No □
If yes, which one(s)?			

Do either of your child's eyelids seem to droop a little more than before?	Yes □ No □
If yes, which one?	
Recently, has your child complained of having a thought that went on and on in their mind, and they couldn't stop it?	Yes □ No □
Has anyone in your child's family had a neurological disease?	Yes □ No □
Recently, has your child reached for something and their hand missed it?	Yes □ No □
Has people's attitudes towards your child seem to have changed?	Yes □ No □
If yes, how?	
When and what was your child's last illness?	
Does your child complain of a ringing or buzzing in their ears?	Yes □ No □
If yes, please explain.	

Sensory Symptoms		
How often has your child smelled strong odors that other people don't smell, such as feces, urine, or smoke? *(Olfactory Disturbance)*	☐ 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	About when did this start? 0-10 how much does this bother them on most days?
How often has your child seen things in their peripheral vision such as stars, bugs, worms, or threads? *(Visual Disturbance)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child seen mice or cockroaches run across the floor, but when they turn to look, they don't see them? *(Visual Disturbance)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child felt as though bugs are crawling on them, or that something is brushing up against their skin, such as a cobweb? *(Haptic Disturbance)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child gone numb in a part of their body for no apparent reason? *(Anesthesias)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child gotten a ringing, buzzing, rushing, or tapping in their ears which comes and goes for no reason? *(Auditory Disturbance)*	☐ 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	About when did this start? 0-10 how much does this them on most days?

How often has your child tried to answer the phone only to find that it had not actually been ringing? *(Auditory Disturbance)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child gotten severe headaches that are so bad that they became nauseated or wanted to throw up? *(Sick Headaches)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child gotten a pain in their head that you would not classify as a headache? *(Head Pains)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child had urinary urgency but did not produce any urine when going to the bathroom? *(Urinary Urgency)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child complained that objects appeared to be much smaller or much farther away than they really are? *(Micropsia)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often have objects appeared to be much larger or much closer to your child than they actually are? *(Macropsia)*	☐ 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	About when did this start? 0-10 how much does this them on most days?

How often has your child become dizzy for no apparent reason? *(Dizziness)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child complained that the room seemed as if it was spinning for no particular reason? *(Vertigo)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child felt like your child complained that their stomach or internal organs are rising up into their chest? *(Epigastric Sensation)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
Anything else? Explain.	☐ 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	About when did this start? 0-10 how much does this them on most days?
Cognitive Symptoms		
How often has your child had trouble pronouncing words with the effect that they appear to be a bit intoxicated? *(Speech Articulation)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child suddenly had trouble thinking of words they should know and were able to say moments before? *(Word Finding)*	☐ 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	About when did this start? 0-10 how much does this them on most days?

How often has your child uttered a sentence that doesn't make sense and involves words other than those they wished to say? *(Confused Speech)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child become quite suddenly and intensely confused and then have the feeling pass in a few minutes? *(Confusion)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child complained that they had an overwhelming feeling that things are weird, strange or wrong, like they've entered the Twilight Zone? *(Jamais Vu)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child complained that they felt that familiar places or people are somehow not familiar or the way they should be? *(Jamais Vu)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child felt that they have experienced something or been someplace before, even though you know they haven't? *(Déjà Vu)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child had clear cut gaps in their memory during which they cannot remember anything over a period of 5 minutes or more? *(Memory Gaps)*	☐ 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	About when did this start? 0-10 how much does this them on most days?

How often has your child found that they have missed major sections of TV shows they have been watching, like someone has spliced out a section of the program? *(Memory Gaps)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child found themselves walking (or driving if they are of age) without remembering how they got there or where they were going? *(Automatisms)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often have people told you about things your child has said or done for which your child has no memory at all? *(Automatisms)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child had staring spells where they become sort of hypnotized by a bright or shiny object? *(Staring Spells)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child felt that their memory or concentration is getting substantially worse every year? *(Mental Decline)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child lost consciousness or just blacked out? *(Loss of Consciousness)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
Anything else? Explain.	☐ 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	About when did this start? 0-10 how much does this them on most days?

Affective Symptoms		
How often has your child been so depressed that they think seriously about suicide? *(Depression with Suicidal Ideation)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child become abruptly more depressed than they were moments ago for no apparent reason? *(Sudden Depression)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child been inclined to panic or become very anxious for no apparent reason? *(Anxiety)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child become extremely and intensely angry for no apparent reason? *(Unprovoked Anger)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child become very angry, yet they do not remember? *(Anger Outbursts)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
Anything else? Explain.	☐ 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	About when did this start? 0-10 how much does this them on most days?
Nocturnal Phenomena		
How often has your child walked or talked in their sleep and appeared capable of interacting with people (even incoherently), performing complex, possibly odd activities, or are able to do	☐ 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	About when did this start? 0-10 how much does this them on most days?

things that are complex or purposeful that another person would think they are awake? *(Parasomnias)*		
How often has your child felt an irresistible urge to sleep during the day, then sleep so soundly that no one can wake them? *(Uncontrollable Sleeping Spells)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child been awakened to realize that they have been sweating so much that the bed sheets are soaked? *(Thermoregulatory Dysfunction)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
How often has your child had vivid nightmares followed by abrupt awakening and insomnia lasting at least one hour? *(Nightmares and Nocturnal Insomnia)*	☐ 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	About when did this start? 0-10 how much does this them on most days?
Anything else? Explain.	☐ 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	About when did this start? 0-10 how much does this them on most days?

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 your child is a party. Therefore, it is different from other psychological or neuropsychological services that your child may have undergone in the past. As the parent or legal guardian, 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 your child personally, the goal is to provide information about how your child is 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 your child is dangerous to themselves or another person or if your child 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 likely be admissible into evidence along with any other information that was provided concerning your child's 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 child's 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 child's participation in this evaluation is voluntary. I will not conduct the evaluation without your consent and your child's assent. Your child also has the right to stop the evaluation at any time. There may be legal consequences if your child chooses to discontinue 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 child's case such as court records, depositions, transcripts, medical records, et cetera. I am not a treating doctor, so your child will not be returning to me for any type of therapy or treatment, although if I think your child would benefit from treatment, I will recommend it in my report.

If, at any time, you or your child have a question about any aspect of the evaluation or these procedures, please feel free to ask me. In addition, if at any time your child needs 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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Sign, Date, and Keep

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Date: _____