



# MidMichigan Neuropsychology Associates, P.L.C.

4705 Towne Centre Road  
Medical Arts I, Suite 304  
Saginaw, MI 48604-2821

Phone: (989) 921-5100  
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## ADULT HISTORY FORM

(Revised 01-01-2022)

DATE: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

MIDDLE INITIAL: \_\_\_\_\_ PREVIOUS NAME: \_\_\_\_\_

IF P.O. BOX, YOU MUST PROVIDE A PHYSICAL ADDRESS. CURRENT WEIGHT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME #: \_\_\_\_\_

\_\_\_\_\_ MOBILE #: \_\_\_\_\_

\_\_\_\_\_ E-MAIL: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ CURRENT AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ ARE YOU RIGHT OR LEFT HANDED?

DRIVER'S LICENSE NUMBER: \_\_\_\_\_ STATE ISSUED: \_\_\_\_\_

IF YOU HAVE A LEGALLY APPOINTED GUARDIAN PLEASE PROVIDE:

GUARDIAN'S FULL NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME #: \_\_\_\_\_

\_\_\_\_\_ MOBILE #: \_\_\_\_\_

\_\_\_\_\_ E-MAIL: \_\_\_\_\_

WHY HAVE YOU BEEN REFERRED TO OUR PRACTICE?: \_\_\_\_\_

WHO REFERRED YOU TO OUR PRACTICE?: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

\_\_\_\_\_ FAX #: \_\_\_\_\_

\_\_\_\_\_ E-MAIL: \_\_\_\_\_

**FAMILY DOCTOR:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

\_\_\_\_\_ **FAX #:** \_\_\_\_\_

\_\_\_\_\_ **E-MAIL:** \_\_\_\_\_

IF YOU ARE SEEING ANY OTHER DOCTORS, PLEASE LIST THEM ON ANOTHER PAGE. BE SURE TO INCLUDE THE ADDRESS, PHONE #, FAX #, AND E-MAIL ADDRESS.

### MEDICAL HISTORY

**BRIEFLY DESCRIBE YOUR CURRENT MEDICAL PROBLEM(S), CONDITION(S) AND DIAGNOSES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (PLEASE CIRCLE)**

- |  |   |
|--|---|
| High Blood Pressure                                  | Diabetes/Hypoglycemia                   |
| Chronic Pain/Chronic Headaches                       | Skin Problems                           |
| Heart Disease  | Anemia/Blood Disorders                  |
| Lung Disease   | Cancer                                  |
| Thyroid Disease                                      | Rheumatoid Disorders                    |
| Kidney Disease                                       | Sexually Transmitted Disease            |
| Liver Disease  | HIV Infection or AIDS                   |
| Exposure to Harmful Chemicals/Gases or Other Poisons | Ulcer/Colitis/Gastritis/Irritable Bowel |
| Loss of Consciousness                                | Encephalitis                            |
| Head Injury  | Meningitis                              |
| Seizures   | Serious Accident/Injury                 |
| Stroke   |   |
| Significant Depression                               | Physical/Sexual Abuse                   |
| Severe Anxiety                                       | Eating Disorder                         |
| Thoughts of Suicide                                  | Sleep Disorder                          |
| Chronic Fatigue                                      | Sexual Dysfunction                      |
|  | Marital Problems                        |
|  | Counseling                              |
|  | Psychiatric Hospitalization             |

**DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR FOODS? (Please List)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IF YOU HAVE EVER BEEN HOSPITALIZED OR HAD SURGERY PLEASE STATE:**

**REASON:** \_\_\_\_\_

**WHEN:** \_\_\_\_\_ **WHERE:** \_\_\_\_\_

IF HOSPITALIZED MORE THAN ONCE, LIST ALL REASONS, WHEN AND WHERE ON ANOTHER PAGE.

**IF YOU HAVE EVER HAD A PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL EVALUATION BEFORE PLEASE STATE.**

**DOCTOR'S NAME:** \_\_\_\_\_

**WHEN:** \_\_\_\_\_ **WHERE:** \_\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER, HERBAL, AND VITAMIN/MINERAL/DIETARY SUPPLEMENTS (BRING ALL MEDICATIONS THAT YOU MAY NEED DURING THE APPOINTMENT WITH YOU):

**MEDICATION NAME**

**DOSAGE (INCLUDE STRENGTH AND FREQUENCY)**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**HAVE YOU EVER BEEN IN COUNSELING? (PLEASE CIRCLE) YES NO**

IF YES, PLEASE STATE REASON(S) AND LOCATION WHERE COUNSELING WAS RECEIVED: \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

\_\_\_\_\_ **FAX #:** \_\_\_\_\_

\_\_\_\_\_ **E-MAIL:** \_\_\_\_\_

**DO YOU NOW OR HAVE YOU PREVIOUSLY USED ALCOHOL? (PLEASE CIRCLE) YES NO**

**AT WHICH AGE DID YOU BEGIN DRINKING?:** \_\_\_\_\_

**WHAT DO YOU DRINK? (e.g. BEER, WINE, LIQUOR):** \_\_\_\_\_

**HOW FREQUENTLY DO YOU DRINK? (PLEASE CIRCLE)**

Daily      Once a week      More than  
once a week      Once every  
two weeks      Less than  
every two weeks      Rarely

**AT THE TIME OF YOUR LIFE THAT YOU DRANK MOST HEAVILY, HOW MUCH WERE YOU DRINKING?**

**HAVE YOU EVER HAD PROBLEMS WITH YOUR HEALTH, JOB, MARRIAGE, FAMILY, FINANCES OR LEGAL PROBLEMS DUE TO YOUR ALCOHOL USE? (IF YES, PLEASE EXPLAIN):** \_\_\_\_\_

**DO YOU NOW OR HAVE YOU PREVIOUSLY USED STREET DRUGS? (IF YES, PLEASE EXPLAIN):**

**DO YOU SMOKE? (IF YES, WHEN DID YOU START AND HOW MUCH DO YOU SMOKE NOW):**

### EDUCATIONAL HISTORY

**YEARS OF EDUCATION (PLEASE CIRCLE):**      **Some High School (# of years \_\_\_\_\_)**

GED      High School      Associate's Degree      Bachelor's Degree      Master's Degree      Doctoral Degree

**HIGH SCHOOL:** \_\_\_\_\_

**CITY/STATE:** \_\_\_\_\_ **LAST YEAR ATTENDED:** \_\_\_\_\_

**COLLEGE/UNIVERSITY:** \_\_\_\_\_

**CITY/STATE:** \_\_\_\_\_ **LAST YEAR ATTENDED:** \_\_\_\_\_

**IF YOU GRADUATED FROM HIGH SCHOOL, PLEASE INDICATE YOUR GRADE AVERAGE (GPA):**

**IF YOU GRADUATED FROM COLLEGE/GRADUATE SCHOOL, WHAT WAS YOUR MAJOR?:**

**HAVE YOU EVER BEEN INFORMED THAT YOU HAVE ANY OF THE FOLLOWING?** (PLEASE CIRCLE):

Learning Disability      Attention Deficit Disorder      Hyperactivity      Behavioral Problems

Autism      Asperger's Syndrome      Fetal Alcohol Syndrome

**WERE YOU EVER HELD BACK A GRADE IN SCHOOL?** (PLEASE CIRCLE):      YES      NO

**WHAT GRADE?:** \_\_\_\_\_

### OCCUPATIONAL HISTORY

**ARE YOU CURRENTLY EMPLOYED?** (PLEASE CIRCLE):      YES      NO

IF YES, EMPLOYER: \_\_\_\_\_ HOW LONG?: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

\_\_\_\_\_ FAX #: \_\_\_\_\_

\_\_\_\_\_ E-MAIL: \_\_\_\_\_

POSITION: \_\_\_\_\_

**WHERE WAS YOUR PREVIOUS EMPLOYMENT?** (OR IF RETIRED WHAT WAS YOUR PRIMARY OCCUPATION?)

NAME: \_\_\_\_\_ HOW LONG?: \_\_\_\_\_

\_\_\_\_\_ PHONE #: \_\_\_\_\_

\_\_\_\_\_ FAX #: \_\_\_\_\_

### SOCIAL HISTORY

**CURRENT MARITAL STATUS:** (PLEASE CIRCLE): Single      Married      Separated      Divorced      Widowed

**HOW LONG HAVE YOU BEEN/WERE YOU MARRIED?:** \_\_\_\_\_

**CURRENT SPOUSE'S NAME:** \_\_\_\_\_

**HOW MANY TIMES HAVE YOU BEEN MARRIED?:** \_\_\_\_\_

**HOW MANY CHILDREN DO YOU HAVE?** (INCLUDE NAME, AGE AND SEX):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE DESCRIBE YOUR CURRENT LIVING SITUATION (WHO YOU LIVE WITH, ETC.):**

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**WHAT DO YOU DO FOR RELAXATION, LEISURE OR HOBBIES?:**

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**ARE YOU CURRENTLY EXPERIENCING STRESS DUE TO FAMILY PROBLEMS, WORK RELATED PROBLEMS, FINANCES, TRAUMATIC EVENTS, OR OTHER CAUSES? (PLEASE DESCRIBE):**

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**HAVE YOU EVER BEEN ARRESTED? (PLEASE EXPLAIN):**

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**ARE YOU CURRENTLY INVOLVED IN A LAWSUIT, CRIMINAL MATTER OR OTHER LEGAL PROCEEDING? (PLEASE EXPLAIN):** \_\_\_\_\_

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**ATTORNEY'S NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

\_\_\_\_\_ **FAX #:** \_\_\_\_\_

\_\_\_\_\_ **E-MAIL:** \_\_\_\_\_

**DO YOU HAVE A CASE MANAGER? (PLEASE CIRCLE):**

YES

NO

CASE MANAGER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

\_\_\_\_\_ FAX #: \_\_\_\_\_

\_\_\_\_\_ E-MAIL: \_\_\_\_\_

**IS THERE ANYTHING ELSE YOU WISH THE DOCTOR TO KNOW ABOUT YOUR PHYSICAL OR PSYCHOLOGICAL HEALTH HISTORY?:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IN CASE OF AN EMERGENCY, WHO WOULD YOU LIKE US TO CONTACT?**

NAME: \_\_\_\_\_ RELATIONSHIP TO YOU: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME #: \_\_\_\_\_

\_\_\_\_\_ MOBILE #: \_\_\_\_\_

\_\_\_\_\_ E-MAIL: \_\_\_\_\_

NEAREST RELATIVE **NOT** LIVING WITH YOU:

NAME: \_\_\_\_\_ RELATIONSHIP TO YOU: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME #: \_\_\_\_\_

\_\_\_\_\_ MOBILE #: \_\_\_\_\_

\_\_\_\_\_ E-MAIL: \_\_\_\_\_

DIRECTIONS TO MIDMICHIGAN NEUROPSYCHOLOGY ASSOC.  
4705 TOWNE CENTRE RD  
MEDICAL ARTS BLD #1 STE 304  
SAGINAW MI 48604  
989-921-5100

FROM 75/675:

ONCE ON 675, TAKE EXIT 6 **TITTABAWASSEE RD**

GO WEST TO **TOWNE CENTRE RD** STOP LIGHT. **there is a Dennys restaurant on corner**

TURN LEFT ONTO TOWNE CENTRE RD (GO APPROXIMATELY 2 BLOCKS)

TURN RIGHT ONTO **COMMERCE DRIVE**

IMMEDIATE LEFT INTO OUR PARKING LOT.

FROM BAY ROAD:

TAKE **TITTABAWASSEE RD** EAST TO **TOWNE CENTRE RD** STOP LIGHT.

TURN RIGHT ONTO **TOWNE CENTRE RD** (GO APPROXIMATELY 2 BLOCKS)

TURN RIGHT ONTO **COMMERCE DRIVE**

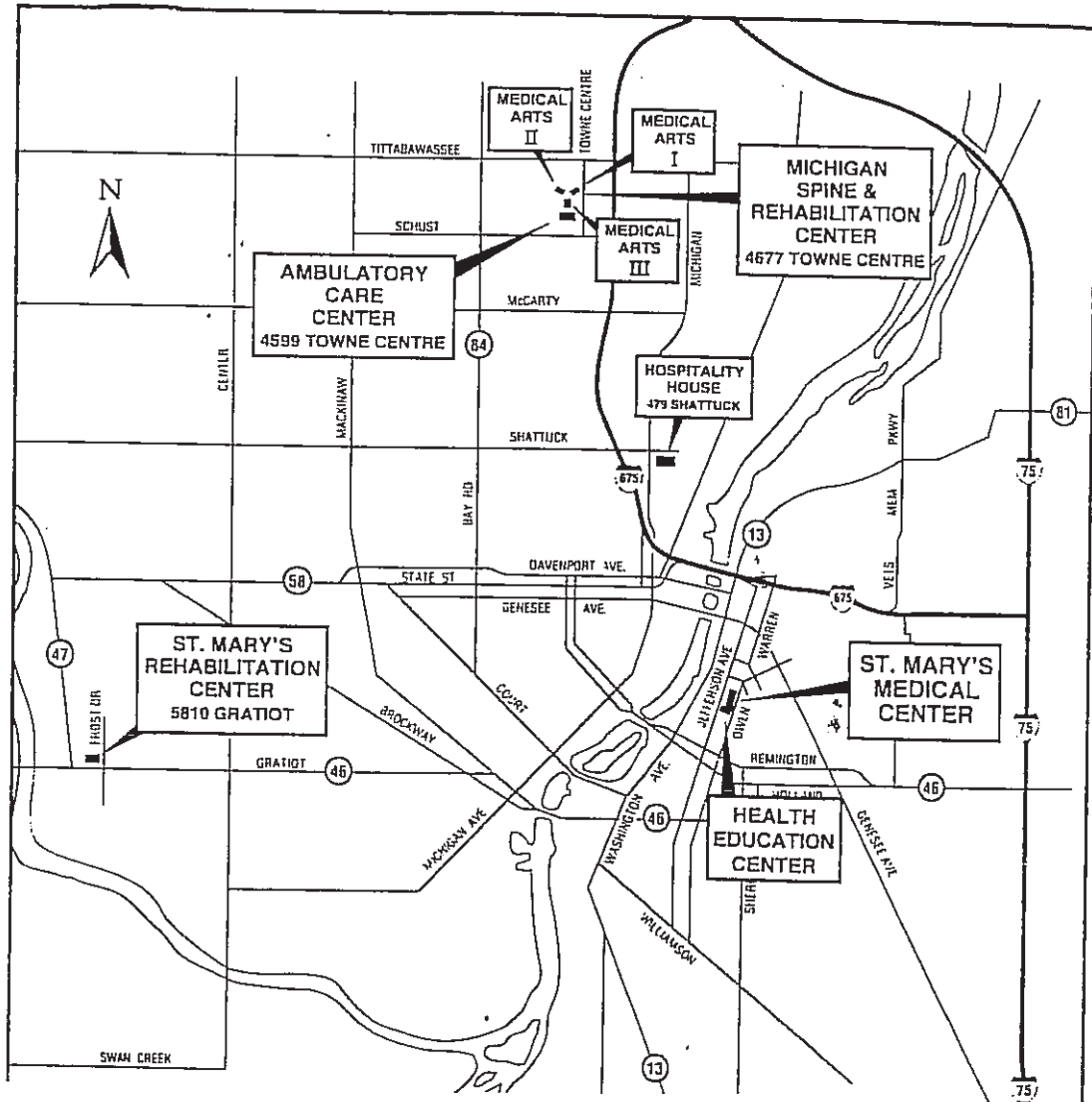
IMMEDIATE LEFT INTO OUR PARKING LOT



# Map to

MidMichigan Neuropsychology Associates, P.L.C.

4705 Towne Center Road  
Suite 304  
Saginaw, MI 48604



# MidMichigan Neuropsychology Associates, PLC

## Patient Authorization, Assignment, and Agreement For Services Performed

Patient Name (Please Print):

I hereby authorize MidMichigan Neuropsychology Associates, PLC, neuropsychologists and/or its designees to release to my insurance company and/or third-party payor(s) and/or external review agency(s) such information contained in my patient record as is necessary for the payment of insurance benefits without regard to any limitations placed on dates, history or illness or diagnostic and therapeutic information including any testing and/or treatment for AIDS, AIDS-Related Complex (ARC) or HIV infection (MI 1989 Public Act 174). This authorization expires upon full payment of insurance benefits unless previously revoked, and may be revoked at any time except to the extent that action has been taken by MidMichigan Neuropsychology Associate, PLC in reliance thereon. I certify information furnished for this claim to be true and correct.

### ASSIGNMENT

I assign to MidMichigan Neuropsychology Associates, PLC, its neuropsychologists and/or designees all rights to benefits, insurance proceeds, settlement payments or judgements I may be entitled for services rendered.

### AGREEMENT

I understand that any amounts not paid by my insurance are my responsibility. Also, I understand that bills not paid within 30 days of services rendered by MidMichigan Neuropsychology Associates, PLC, may be charged 1.5% service charge per month (18% APR ) on any unpaid balance.

### MEDICARE PATIENTS

I request payment to MidMichigan Neuropsychology Associates, PLC of authorized Medicare benefits for any services furnished by MidMichigan Neuropsychology Associates, PLC, rendered on my behalf. I authorize any holder of medical or other information about me to release to Health Care Financing Administration, its agents and other carriers, any information needed to determine these benefits or benefits for related services. This request is effective until revoked in writing.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Closest Relative or  
Legal Guardian (if Applicable)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Relationship

## Notice of Privacy Practices Short Form

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rules, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

### **What is HIPAA and how does the privacy rule affect you?**

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The

Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by

following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

### **What is individually identifiable health information (IIHI)?**

Any health information you provide, including your mailing address, information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

### **The following categories best describe the different ways in which we may use and disclose your IIHI:**

Treatment, Appointment Reminders, Release of Information to Family/Friends,  
Payment, Treatment Options, Disclosures Requires by Law  
Healthcare Operations, Health Related Benefits and Services

### **The following categories describe unique situations in which we may use or disclose your IIHI:**

Public Risks, Health Oversight Activities, Lawsuits, Law Enforcement  
Serious Health Threats/Safety, Research

### ***You may request to view our full Notice of Privacy at anytime.***

The undersigned Patient or legally authorized representative "Agent" of the Patient acknowledges that he or she personally received or was offered a copy of the MidMichigan Neuropsychology Associates Notice of Privacy Policies.

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date