Minh-Thu T. Le, PhD, ABPP
Clinical Neuropsychology
Phone: (310) 869-1050
Fax: (714) 379-0187

RE: Neuropsychological Consultation

Please have the following form(s) completed and bring with you to your appointment. Please also bring any personal items you may need such as glasses, hearing aids, and medications. Get as much rest as possible and eat breakfast/lunch prior to your appointment. Unless an alternate arrangement has been made, the testing will take several hours (with short breaks included) to complete.

The office is located at **3415 S. Sepulveda Boulevard, Suite 1100**. The nearest cross street is Palms Boulevard. It is a lone glass/mirror building. You can park in the parking structure right next to the building. Follow the sign for Visitors Parking. Once in the building, check in with security and let them know that you are coming to see me on the 11th floor (Suite 1100/Regus). You will then be able to take the elevator to the 11th floor. Once there, go to the reception desk and let them know that you have an appointment with me. At the time of your appointment, I will come and escort you to my office. (You can also call me directly and I can meet you in reception.)

Please feel free to contact me at (310) 869-1050 if you have any questions.

Thank you.

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BACKGROUND INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Marital Status: _____ Gender: _____

Place of Birth: _____ Where Raised: _____

First Language Learned: _____ Language(s) Spoken at Home: _____

Primary Language: _____

	AGE	EDUCATION	OCCUPATION
Brother(s):			
Sister(s):			
Mother:			
Father:			
Spouse:			
Son(s):			
Daughter(s):			

Education: Highest level/grade completed: _____ Where: _____

Grades in high school: _____ Grades in college: _____

Best/favorite subjects: _____

Worst/least favorite subjects: _____

Special education classes or tutoring?: _____

Speech or language difficulties as a child?: _____

Means of financial support: _____

3415 South Sepulveda Boulevard .. Suite 1100 .. Los Angeles, Ca. 90034
11770 Warner Avenue .. Suite 110 .. Fountain Valley, Ca. 92708

	JOB TITLE	COMPANY	LENGTH
Current occupation:			
Past employment(s):			

History of head injury?: Yes No

Yes: When: _____ With or without loss of consciousness?: _____

Briefly describe circumstance of head injury: _____

_____

Problem with vision?: _____

_____

Problem with hearing?: _____

_____

Present medical health problem(s) or condition(s): _____

_____

_____

All current medications (name & daily dosage): _____

_____

_____

Past medical health problem(s) or condition(s): _____

_____

_____

Past or present participation in psychotherapy (please specify reason for and length of therapy): _____

_____

_____

Have you been given a psychiatric diagnosis?: _____

Have you been prescribed medication(s) for a mental or nervous condition? (please specify what medication and when):

_____

_____

Medical problem(s) including neurological disorders (such as stroke, Parkinson's, Alzheimer's, epilepsy) in family:

Relative: _____ Problem: _____

Relative: _____ Problem: _____

Relative: _____ Problem: _____

Relative: _____ Problem: _____

Relative: _____ Problem: _____

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History of psychiatric illness in family:

Relative: _____ Diagnosis: _____

Relative: _____ Diagnosis: _____

History of drug use (including cigarettes & alcohol):

NAME/TYPE OF DRUG	FREQUENCY OF USE	DURATION OF USE

Prior psychological or neuropsychological assessment:

When: _____ By whom: _____

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When: _____ By whom: _____

If necessary, please use the back to explain your responses to the following questions:

1. How do you get along with:

   Your mother?: _____

   Your father?: _____

   Your brother(s) and/or sister(s)?: _____

   Your spouse or significant other?: _____

   Your children?: _____

   Your friends?: _____

   Your co-workers?: _____

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2. Who or what is most likely to upset you? _____

3. When you become angry, do you tend to strike out or do you tend to "keep it in" and withdraw? _____

4. How often do you lose your temper? _____

5. Have you ever hit anyone? If yes, when and why? _____

6. Have you ever been arrested? If yes, when and why? _____

7. Do you often feel tense, nervous, or anxious? _____

8. Do you often feel sad or depressed? _____

9. Do you now or have you ever had thoughts of hurting or killing yourself? If yes, when and how? _____

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10. Do you have trouble controlling your anger? _____

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11. Do you ever feel overly energetic? _____

12. Do you often feel a complete lack of motivation? _____

13. Do you have trouble handling responsibility? _____

14. Do you have trouble managing your money? _____

15. Do you have trouble working safely? _____

16. Do you have trouble remembering things that happened in the recent past (such as what happened last week or last month)? _____

_____

17. Do you have trouble remembering things from conversations you have had in the recent past?_____

_____

18. Do you have trouble remembering people's names? _____

19. Do you have trouble remembering what you have read? _____

_____

20. Do you have trouble remembering how to walk or drive to a certain place? Do you have trouble finding your way around an area you are familiar with? _____

_____

21. Do you have trouble understanding or following a conversation? _____

_____

22. Do you have trouble understanding what you read? _____

_____

23. Do you ever have trouble speaking such as slurring your words, stuttering, being unable to put simple thoughts into words? If yes, please describe: _____

_____

24. Do you have trouble coming up with the words you want to use in conversation? _____

_____

25. Do you have trouble coming up with the names of simple objects? _____

_____

26. Do you have trouble paying attention even when you want to and are trying? _____

_____

27. Have you ever seen, heard, or smelled things that other people could not? If yes, please describe: _____

_____

_____

_____

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PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Date of Birth: _____

Social Security#: _____ Marital Status: _____

INSURANCE COMPANY 1: _____

Insurance Mailing Address: _____

_____

Telephone (Customer Service): _____

Insured Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security#: _____

Insurance ID#: _____ Group#: _____

INSURANCE COMPANY 2: _____

Insurance Mailing Address: _____

_____

Telephone (Customer Service): _____

Insured Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security#: _____

Insurance ID#: _____ Group#: _____

I authorize payment of benefits to be paid directly to Dr. Minh-Thu T. Le and I understand that I will be responsible for any deductible, coinsurance and/or co-payment amounts. I also authorize Dr. Le to release to my insurance company all information required in the processing of this claim. In the event that this claim is incorrectly processed by my insurance company, I authorize Dr. Le to file a complaint with the Dept. of Insurance and the Dept. of Managed Health Care and to release to these agencies all pertinent information. I am aware that Dr. Le uses electronic billing when possible. A copy of this authorization shall be considered as effective and as valid as the original.

(The following paragraph is not applicable for Medicare, Blue Shield of California, Anthem Blue Cross, United Health Care, or Cigna Health Care subscribers.) I understand that the service will be provided out-of-network. In the event that payment is sent directly to me, I agree to immediately forward the payment and the explanation of benefits (EOB) to Dr. Le. I am aware that I will be responsible for the full charge if the insurance payment and the EOB are not forwarded to Dr. Le.

Signature: _____ Date: _____

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