CRCNJ
The Cognitive and Research Center
of New Jersey, LLC
Directed by Michelle Papka, Ph.D.

No-Cost Memory Screening, NOT Medical Care

We are offering memory screenings at no cost to you. The purpose of the Memory Screens is to determine if you are eligible for a clinical trial or if you may benefit from a more comprehensive evaluation or services. The assessments are NOT being performed for the purposes of diagnosis, treatment or other medical care. You should consult with your healthcare provider(s) for any and all patient care needs, including diagnosis, treatment and other medical care.

No written feedback will be provided, however recommendations will be discussed at the time of screening. Per your request, a summary of the test scores can be sent to your doctor's office.

We would like to add your information to our database so that we may contact you in the future, should you potentially qualify for a study. Please indicate below whether you grant The CRCNJ permission to do so.

_____Yes _____No

I acknowledge the above statement and understand and agree.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

Main Office / All Correspondence:
195 Mountain Avenue
Springfield, NJ 07081

TheCRCNJ.com
Phone: 973-850-4622
Fax: 973-850-4621
NJ Psychology License #35S100381300

575 Route 28
Building 2, Suite 2108
Raritan, NJ 08869

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Patient Information and Questionnaire

Name: _____ Date of Birth: _____Age: _____ Gender: _____ Height: ____ Weight: _____

Home Address: _____

Phone Number: _____(H) _____(C)

Email: _____

Contact Name (if Different than Patient): _____

Address: _____

_____

Phone Number: _____(H) _____(C)

Email Address: _____

Is the contact a legal guardian or holder of POA/Health Proxy? ◯Yes ◯No *If yes, please provide documentation. **

The CRCNJ respects your right to confidential communication about your protected health information (PHI). As specified by you below, The CRCNJ will use the provided phone numbers and emails to leave messages about services and educational events.
◯Yes ◯ No

Referring Physician or Source (Name and Specialty), if applicable: _____

Relevant History:

What are you experiencing in your daily life that has caused you to seek a memory screening?

_____

When did these symptoms begin? _____ (approximate date) ◯Gradual Onset ◯Sudden Onset

Have the symptoms changed in the past month? ◯ worse ◯ better or ◯ same

Have you recently been evaluated by a neurologist or psychiatrist or had any related testing?

_____

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Past Medical History: Do you **have** any of the following medical conditions?

	YES	NO		YES	NO
Visual Loss	○	○	Fainting or blackouts	○	○
Glaucoma	○	○	Seizures/epilepsy	○	○
Loss of Hearing	○	○	Seizures with high fever as child or baby	○	○
Recurrent Vertigo	○	○	Head trauma w/loss of consciousness	○	○
High Blood Pressure	○	○	Hematological disorders (sickle cell, hemophilia)	○	○
High Cholesterol	○	○	Bleeding tendency	○	○
Heart disease (angina, heart arrhythmia)	○	○	Diabetes	○	○
Lung disease (emphysema, COPD, asthma)	○	○	Thyroid condition	○	○
Gastrointestinal disease/Incontinence	○	○	Immunologic disorders (rheumatoid arthritis, lupus)	○	○
Liver disease	○	○	Chronic allergies/hay fever	○	○
Chronic skin condition	○	○	Kidney disease or other urological disorders	○	○
Arthritis	○	○	Infectious Diseases (Tuberculosis, HIV< Encephalitis)	○	○
Chronic sleep disorders	○	○	Infections (Lyme)	○	○
Stroke or TIA	○	○	Cancer	○	○
Alzheimer's or other cognitive disorders	○	○			
Parkinson's or other movement disorders	○	○			
Frequent Falls/imbalance	○	○			
Tremor/shaking/involuntary movement	○	○			

Additional Relevant History: Please explain

_____

Current Medications:

Please list any medications you are currently taking including over the counter medications, supplements and vitamins.

Medication	**Start Date**	**Reason for Medication**	**Strength** (mg/ml)	**Dosing** (frequency per day)

☐ Please check here if there are additional medications and a complete list was provided separately.

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If not listed in above current medications, have you ever taken any of the following medications for cognitive symptoms?

Medication	Yes	No	If so, when?
Aricept® (donepezil)	○	○	
Exelon® (rivastigmine)	○	○	
Namenda® (memantine)	○	○	
Namzaric® (memantine and donepezil)	○	○	
Razadyne® (galantamine)	○	○	

Psychiatric History: Have you ever experienced or received treatment for?

	Yes	No		Yes	No	Describe
Depression	○	○		○	○	
Anxiety	○	○		○	○	
Agitation	○	○	Any Psychiatric Hospitalizations?	○	○	If yes, when?
Hallucinations	○	○	Currently seeing a Psychologist or Therapist?	○	○	If yes, who?
Delusions	○	○	Currently seeing a Psychiatrist?	○	○	If yes, who?

Neuropsychiatric Work-up: Please use the chart below to describe any current or pending assessments by a neurologist or psychiatrist or any related testing:

Type of Evaluation or Test	Physician or Facility	Date	Results	Provided to CRCNJ (Y/N)
Neurological Evaluation				
Neuropsychological Evaluation				
MRI				
CT				
Blood Work				
PET (FDG or Amyloid)				
EEG				

Family History:

Does anyone in your family (i.e., blood relative) have a history of **neurological** or **psychiatric** illness? Please use the chart below to list these relatives and their history.

Family Member/Relation	Illnesses	Age of Onset of Illness

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Social History:

How many years of education did you complete? _____ Highest degree you obtained? _____
Are you retired? ◯ Yes ◯ No If Yes, for how many years? _____
If No, what is your current occupation? _____
For how long have you been at your current job? _____
Please describe your previous employment history: _____

What is your marital status? ◯ Single ◯ Married ◯ Widow ◯ Divorced
If married, for how many years? _____If divorced or widowed, for how many years? _____
Do you have any children? ◯ Yes ◯ No If yes, how many? _____
Who do you live with? _____

Do you need assistance with daily activities (e.g. grooming, dressing, driving, finances)? ◯ Yes ◯ No
If yes, please explain_____
Do you have adequate help and support? ◯ Yes. ◯ No

Do you have a driver's license? _____ If so, which state? _____
How do you like to spend your leisure time? _____
Do you exercise regularly? ◯ Yes. ◯ No If so, how _____

Alcohol/Drug Use:

Do you smoke cigarettes? ◯ Yes ◯ No ◯ In the past. If yes, how many per day? _____
If yes, for how long have you been smoking? _____
If in the past, how many per day? _____
If in the past, for how long? _____
Do you, or have you ever, used any illicit drugs? ◯ Yes ◯ No
If yes, please describe: _____
Do you consume alcohol? ◯ Yes ◯ No If yes, please describe daily or weekly use: _____

Have you ever participated in a clinical trial? ◯ **Yes** ◯ **No** If so, provide more info: _____

Did the patient fill out this questionnaire? ◯ Yes ◯ No
If No, who completed this form:_____

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Authorization Form for Protected Health Information (PHI)

This form, when completed and signed by you, authorizes The Cognitive and Research Center of New Jersey, LLC ("The CRCNJ") to release Protected Health Information ("PHI") from your clinical record to the person you designate, and to obtain PHI from entities designated by you. **Please note, that, as per our standard practice, we will automatically send a copy of the neuropsychological reports to the referring physician.**

You have the right to revoke this authorization, in writing, at any time, by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Please complete the following:

I, _____authorize The Cognitive and Research Center of New Jersey, LLC to

☐ Release
☐ Obtain
☐ Discuss on an ongoing basis:

With the following individuals (please provide the name of the doctors or family members):

_____
_____
_____

☐ All Records
☐ Specific records only (provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.):_____

I am requesting The CRCNJ to release/obtain this information for the following reasons:

☐ At the request of the individual – (if you are a patient of The CRCNJ and you do not desire to state a specific purpose)
☐ Other purpose (please specify)

_____

This authorization shall remain in effect until:

☐ Expiration date _____
☐ Until further notice

I am aware of my right to confidential communications under psychologist -patient privilege. **I understand that my psychologist generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.**

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by designated recipients and may no longer be protected by the HIPAA Privacy Rule. If authorizing the use or disclosure of psychotherapy notes, I understand that such authorization cannot be required as a condition of treatment, payment, enrollment, or eligibility for benefits.

_____ _____
Signature of Patient Date

_____ _____
Print Name of Patient Date of Birth

_____ _____
Signature of Legal Guardian* (Relationship) Date

_____
Print Name of Legal Guardian* (Relationship)

**If the authorization is signed by a personal representative of the patient, a description and documentation of such representative's authority to act for the patient must be provided.*

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