

**Psychiatric Associates**  
**Alycia Bellah, PhD, PLLC**  
**Lloyd Bellah, MD**

**1650 W. Virginia St #202**  
**McKinney, Texas 75069**

**972-542-5980**

Today's evaluation is for: DARS/DDS <input type="checkbox"/> Neuropsychological <input type="checkbox"/> Other:				
Place Tested:			Today's Date:	
Person Completing Form (if not the examinee):				
How are you related to the examinee?				
<b>PATIENT INFORMATION</b>				
Patient's Last Name	First	Middle	Birthdate	Age
SSN:		Email Address:		
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Caucasian (White) <input type="checkbox"/>	Never Married <input type="checkbox"/> Married <input type="checkbox"/>		
Right handed: <input type="checkbox"/>	Hispanic <input type="checkbox"/> African American <input type="checkbox"/>	Separated <input type="checkbox"/> Divorced <input type="checkbox"/>		
Left handed: <input type="checkbox"/>	Other <input type="checkbox"/>	Widowed <input type="checkbox"/> Living Together <input type="checkbox"/>		
Street Address		City	State and Zip	
Phone: (    )			Cell: (    )	
Emergency Contact:			Phone: (    )	

**Medications**

Please list all medications you are currently taking, along with information regarding what disorder they are prescribed to treat, the dosage, and when you take them. <i>Please include all over-the-counter, herbal, and "nontraditional" medicines.</i>			
Name of medicine	Taken for ?	Dosage	When/How often?
What side effects do you experience of your medications (if any)?			

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

**Additional information.**

If there is anything else that you think is important for us to include in your report to help decide on appropriate action for your case, please include it in the space below.

*Thank you for completing this form.*