LAST NAME	FIRST NAME	DOB:	AGE:	SEX:

PHONE AND PHYSICAL ADDRESS AND PHONE NUMBER WHERE YOU CAN BE CONTACTED/LOCATED DURING EVALUATION

STREET ADDRESS:		**PHONE:**	
APT/SUITE#:	**CITY:**	**STATE:**	**ZIP:**
EMAIL:			

CHIEF COMPLAINT(S)/CONDITIONS

Condition/Diagnosis/Problem	Year It Began

CHECK ALL ASSISTIVE DEVICES YOU USE:

☐ **Cane** ☐ **1 Crutch** ☐ **2 Crutches** ☐ **Walker** ☐ **TENS Unit** ☐ **Wheelchair**
☐ **Other (Specify)**

FOR FEMALE CLAIMANTS ONLY: ARE YOU CURRENTLY PREGNANT? ☐ YES ☐ NO

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS

LIST ALL OPERATIONS AND HOSPITAL ADMISSIONS

YEAR	NAME OF HOSPITAL	REASON

HAS A DOCTOR EVER TOLD YOU THAT YOU HAVE OR HAD THE FOLOWING?	**YES**	**NO**	**YEAR IT BEGAN**
HIGH BLOOD PRESSURE	☐	☐	
DIABETES	☐	☐	
HEART ATTACK	☐	☐	
OTHER HEART DISEASE	☐	☐	
ASTHMA	☐	☐	
EMPHYSEMA	☐	☐	
SEIZURES	☐	☐	
HEAD INJURY	☐	☐	

IMA PA Adult Medical History Form (PA) (NYS and ALL states)

MEDICATIONS – LIST ALL OF THE MEDICATIONS YOU ARE CURRENTLY TAKING

NAME OF MEDICATION	DOSE	FREQUENCY (HOW OFTEN)

SOCIAL HISTORY

HAVE YOU EVER USED: PLEASE CHECK ANY THAT APPLIES	When did you start? YEAR	Do you still use? YES NO	If yes, how much do you use daily?	If not, when did you stop?	What was the most you ever used?
☐Cigarettes ☐Cigars ☐Pipe ☐ Chewing Tobacco		☐ ☐			
☐Beer ☐Wine ☐Liquor		☐ ☐			
☐Marijuana		☐ ☐			
☐Cocaine ☐Heroin		☐ ☐			
☐Other _____		☐ ☐			

ACTIVITIES OF DAILY LIVING

Do you live alone? ☐YES ☐NO If not, with whom do you live? _____

Do you need help at home? ☐YES ☐NO *(i.e. home health aide, case manager, family, other)*

Are you currently licensed to drive? ☐YES ☐NO Additional Comments: _____

If YES, do you currently operate a motor vehicle? ☐YES ☐NO

Which of these can you do?	How many times a week?	If you don't, why not?
☐ Cooking		
☐ Cleaning		
☐ Laundry		
☐ Shopping		
☐ Childcare		
☐ Shower/Bathe by yourself		
☐ Dress yourself		

Check off the Activities you do:

☐Watch TV ☐Listen to the Radio ☐ Read ☐ Online Social Media Activities ☐ Plays Video Games (Mobile/Console/PC)

☐ Play Sports ☐ Socialize with friends ☐ Go out to: _____

☐ Have a hobby: _____

Name and Phone Number of Primary Care Physician:	NAME:
	PHONE:

IMA Adult Psych History Form Online 5102020

LAST NAME	FIRST NAME	DATE OF BIRTH	AGE	GENDER

1. Marital Status: ❑ Single ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

2. How did you get here today? ❑ Drove self ❑ Walked ❑ Driven by _____
   ❑ Public Transportation (specify) _____
3. How many miles did you travel to get here today? _____ miles.

4. What is your highest level of education? ❑ Elementary School ❑ High School Graduate ❑ Obtained GED
   ❑ College (How many Years?) ❑ Post-Graduate ❑Other
   ❑ Vocational Training Program-Type:
   Was it completed? ❑ YES ❑ NO

5. Type of Education Placement: ❑ Regular ❑ Special Education for

6. What is your current Employment Status? ❑ Not Employed
   ❑ Employed Part-time as a _____ since _____
   ❑ Employed Full-time as a _____since _____

7. If you are currently not working, what was your last job title? _____
   When were you last Employed? _____ How long did you work there? _____ that was your reason for leaving? _____

8. If you have been unable to work, please state reasons:

   _____

9. **Have you ever been hospitalized for PSYCHIATRIC reasons?** ☐ YES ☐ NO

DATES	NAME OF HOSPITAL	REASON FOR HOSPITALIZATION	DIAGNOSIS

10. **If you are or have been in treatment with a counselor, psychiatrist or psychologist, please list below:**

DATES	FREQUENCY OF TREATMENT	WHERE?	WITH WHOM?

11. Have you had any significant symptoms of depression, anxiety or other emotional problems during the past few months? ❑ YES ❑ NO If yes, please describe:

    _____

12. If you If you are receiving mental health treatment, how would you describe your current condition?
    - ☐ My symptoms are controlled by treatment.
    - ☐ Improved, but occasionally experience symptoms.
    - ☐ Symptoms are worse.
    - ☐ Improved, but still experience symptoms.
    - ☐ My condition has not improved.

13. Please describe your sleeping habits.
    ☐ Normal. ☐ Difficulty falling asleep. ☐ Wake up usually _____ times nightly. How long? _____

14. How is your appetite?
    ☐ Normal. ☐ Loss of appetite. ☐ Increased appetite.
    ☐ Weight Loss of _____lbs.
    ☐ Weight gain of _____ lbs.
15. Do you currently drink alcohol? ☐ YES ☐ NO
    If yes, how often? _____ How much? _____
    If yes, check all that apply: ☐ Beer ☐ Wine ☐ Liquor
    If you no longer drink, when did you stop? _____
    Do you have a history of Alcohol abuse? ☐ YES ☐ NO

16. Do you use drugs? ☐ YES ☐ NO
    If yes, how often? _____ How much? _____
    If yes, check all that apply: ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other: _____
    If you no longer use, when did you stop? _____
    Do you have a history of Substance abuse? ☐ YES ☐ NO

If you have been (or are currently in) an alcohol or drug treatment program please complete:

DATES	FACILITY NAME	TYPE OF TREATMENT	RESULTS OF TREATMENT

17. Have you ever been arrested? ☐ YES ☐ NO If yes, date: _____
    Charges: _____

    Sentence: _____

    Current Legal Status: _____

18. Have you ever served in the Military? ☐ YES ☐ NO

    If yes, Dates: _____ Branch: _____ Discharge Type: _____

19. Is there a family history of any of the following?
    Psychiatric Illness: ☐ YES ☐ NO If yes, please explain: _____
    Alcohol and/or Drugs: ☐ YES ☐ NO If yes, please explain: _____
    Cognitive Problems: ☐ YES ☐ NO If yes, please explain: _____

IMA
THE IMA GROUP

TELE-ASSESSMENT INFORMED CONSENT

This Informed Consent provides the terms and conditions for my psychological evaluation that is being conducted by an IMA Group provider using teleconferencing (hereinafter referred to as "tele-assessment") technology. Document will be signed through encrypted technology before the exam takes place.

I, as the claimant, receiving assessment services through tele-assessment technologies, I understand:

1. Teleassessment is the delivery of evaluation services using interactive technologies (use of audio, video or other electronic communications) between a provider and an individual who are not in the same physical location. The interactive technologies used in teleassessment incorporate network and software security protocols to protect the confidentiality of individuals' information transmitted via any electronic channel. While the videoconferencing technology we employ is secure and private, the manner in which it may be used may allow your personal information to be accessed by unauthorized third parties. It is important to use a secure internet connection rather than public/free Wi-Fi.

2. Confidentiality still applies for teleassessment services. The teleassessment interview is completely private, and nobody other than the provider and the claimant is authorized to listen in. It is my responsibility to maintain privacy on my end of any electronic communication. Audio data will not be recorded, saved, or stored in any way. I am also prohibited from recording the interview or taking screenshots.

3. It is important to be in a quiet, private space that is free from distractions (including other people and cell phones or other devices). It is important that I speak clearly for best results. It is also important that the examiners speak clearly. I will tell the provider if I have any problems hearing what they say. I will ask that questions be repeated if I'm not sure I understand.

5. We need a back-up plan to restart the assessment in the event of technical problems. Thus, I will provide the provider a phone number where I can be reached in the event this occurs.

6. I understand that if I do not give my consent to the use of teleassessment for my interview, an attempt to arrange an in-person interview will be made but could be delayed given current circumstances. My request for an in-person exam will not be held against me by the provider and will in no way influence their conclusions or recommendations.

I, as the claimant, acknowledge and accept the privacy risk and I am willing to voluntarily participate in a consultative examination using Zoom for Healthcare.

_____ _____

Signature of Claimant
Parent/Guardian if under 18

Date Signed