Dr Katie Hamilton

BA (WITS), BSocSci Hons (UCT), MA Neuropsychology (UCT), PhD Psychology (UCT)

PATIENT	
Full Name:	
ID No.:	
Email Address	
Cell Number:	
Physical Address:	
MEDICAL AID	
Medical Scheme & Plan:	
Medical Aid Membership Number:	
Main Member Name & ID:	
EMERGENCY CONTACT	
Name:	
Cell number:	
Relationship:	
SIGNATURE	
Signature & Date:	

HPCSA: PS 0146463 • Practice: 0939986 • email: katie@hamilton.co.za • cell: 083 413 5797
Room 311 East Wing, Mediclinic Morningside Hospital, Rivonia Road, Sandton
www.katiehamilton.co.za

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NEUROPSYCHOLOGY: INTAKE QUESTIONNAIRE.

REFERRAL INFORMATION	
Reason for referral:	
Referred by:	
MEDICAL / REHABILITATION TEAM	
Please provide the names of your treatment team if you are seeing any of the following:	
GP:	
Psychiatrist:	
Psychologist / Counsellor:	
Neurologist:	
Neurosurgeon:	
Speech Therapist:	
Physiotherapist:	
Occupational Therapist:	
Other relevant medical / clinical professionals:	
MEDICATION	
Please list all medications and reasons for taking them:	

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HEALTH		
Have you experienced any of these illnesses/incidents that could affect neurological functioning:	☐ Concussion ☐ Stroke ☐ Heart Attack ☐ Heart Disease ☐ Seizure / Epilepsy ☐ Meningitis / Encephalitis ☐ Traumatic Brain Injury ☐ Cancer ☐ Psychiatric Diagnosis (e.g. Depression, Anxiety, Bipolar Disorder, etc.)	
Please list all current medical diagnoses:		
Dominant hand:	☐ Left handed ☐ Right handed ☐ Ambidextrous	
EMPLOYMENT & EDUCATION		
Employment status:	☐ Working ☐ Retired ☐ Unemployed but able to work	Medical Boarding ☐ Temporary ☐ Permanent
Current job title (or last job title if currently not working):		
Highest Level of Education:		

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