Alyson L. Aviv, Ph.D.
Licensed Psychologist
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ADULT COGMED DATA FORM

Date: _____

Name: _____ **Date of Birth:** _____ **Age**:_____

Male____ Female____

Marital Status:

_____ Married (How long? _____ years)
_____ Separated
_____ Divorced
_____ Single
_____ Widowed

Address:_____

Phone: _____ (H) _____(W) _____(C)

Family Email(s) _____

Current learning and/or psychiatric diagnoses _____
Who diagnosed_____
Known genetic disorders or medical diagnoses:_____

Name of Current Medication(s)	Dosage	Since (date)

Are you employed? _____Yes _____No (if yes, specify how long job held and # hours/week)

IMPACT SCALE:

Rate yourself for the following abilities on a five point scale by placing an X in the appropriate box

	Poor				**Excellent**
	1	**2**	**3**	**4**	**5**
Paying Attention and Listening					
Being Calm					
Controlling Impulses					
Getting started on tasks					
Remaining focused on tasks					
Ability to remember things (daily schedule etc.)					
Reading and Understanding					
Following Conversation					
Keeping your home tidy and organized					
Personal hygiene/grooming					
Managing routine tasks					
Multitasking effectively					
Time management overall					
Getting along with family members					

What specific measurable goals do you have?

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Adult Consent for COGMED

I, _____ am requesting COGMED.

I understand that these services will be rendered by Dr. Alyson Aviv, a licensed clinical psychologist. I consent to receive these services.

I understand that all information is kept strictly confidential and cannot be released without my written permission.

I understand that I must set aside 5 times/week to do the COGMED exercises over a 5 week period and that my results will depend on the effort I put in to the program.

I understand that Dr. Aviv is working with me as my COGMED coach.

I also acknowledge that I have been provided with Dr. Aviv's notice of privacy practices.

_____ _____
Name Signature

_____
Date