

All information collected is confidential and is protected. We will not share information with other parties without written consent.

Date: _____

Adult Neuropsychological History

Name of person filling out form _____ Relationship to patient _____
Patient Name: _____ Sex: _____ Age: _____
Date of Birth: _____ Employer: _____
Address: _____
Home Phone: _____ Work Phone: _____
Referred By: _____ Reason For Referral: _____

History of Present Injury/Illness

Date of Injury/Illness: _____

Please describe onset of injury/illness, dates, names of hospitals and physicians, operations, types of treatment, etc.:

A. Symptom Survey

Place a check beside each symptom that currently applies. Please also circle the symptom if it existed previous to the injury/illness.

1. PHYSICAL

- | | |
|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Loss of bowel control |
| <input type="checkbox"/> Excessive tiredness | <input type="checkbox"/> Blackout spells (fainting) |
| <input type="checkbox"/> Pain (Indicate location): _____ | |
| <input type="checkbox"/> Other physical problems: _____ | |

2. SENSORY

Check the side this occurs on:

	Right Side	Left Side	Both Sides
Loss of feeling or numbness			
Tingling or strange skin sensations			
Difficulty telling hot from cold			
Problems seeing on one side			
Blurred vision			
Blank spots in vision			
Brief periods of blindness			
Seeing "stars" or flashes of light			
Difficulty hearing			
ringing in ears			
Hearing strange sounds			
Difficulty tasting food			
Difficulty smelling			
Smelling strange odors			
Double vision			
Difficulty looking quickly from one object to another object			
Other sensory problems (describe)			

3. MOTOR AND COORDINATION

Check the side this occurs on:

	Right Side	Left Side	Both Sides
Fine motor control problems (using a pencil)			
Weakness on one side of body			
Difficulty holding on to things			
Tremor or shakiness			
Muscle tics or strange movements			
Writing is very small			
Writing is very large			
Walking more slowly than other people			
Jerky muscles			
Difficulty starting to move			
Muscles tire quickly			
Often bumping into things			
Other motor or coordination problems (describe)			

4. NONVERBAL SKILLS

- Difficulty telling right from left
- Problems drawing or copying
- Difficulty recognizing objects or people
- Unaware of things on one side of your body: [] Right side [] Left side
- Difficulty doing things that s/he should automatically be able to do (e.g., brushing teeth)
- Seems unable to recognize facial or body expressions of disapproval or emotions
- Difficulty with puzzles, Legos, blocks, or similar games
- Other nonverbal problems: _____
- Gets lost easily
- Problems finding way around places that you been before
- Slow reaction time

5. SPEECH, LANGUAGE AND ACADEMIC SKILLS

- Unable to speak
- Difficulty spelling
- Difficulty finding the right words to say
- Difficulty staying with one idea during a conversation
- Difficulty understanding what others are saying
- Difficulty writing letters or words (not due to motor problems)
- Difficulty verbally describing the steps involved in doing something
- Other speech, language, or academic skills problems: _____
- Slurred speech
- Difficulty with math
- Odd or unusual speech sounds
- Difficulty expressing thoughts in an organized way
- Difficulty reading phonetically
- Difficulty with reading comprehension

6. CONCENTRATION AND AWARENESS

- Highly distractible Loses train of thought
 Problems concentrating Becomes easily confused or disorientated
 Mind appears to go blank at times Doesn't appear very alert or aware of things
 Other concentration or awareness problems: _____

7. PROBLEM SOLVING

- Difficulty with reasoning or figuring out how to do new things
 Difficulty with planning and organization
 Difficulty figuring out problems that a younger child can do
 Difficulty thinking as quickly as needed
 Difficulty doing things in the right order (sequencing problems)
 Difficulty changing a plan or activity when necessary
 Difficulty completing an activity in a reasonable amount of time
 Difficulty doing more than one thing at a time
 Difficulty switching from one activity to another activity
 Other problem solving difficulties: _____

8. MEMORY

- Forgetting where you leave things (e.g., toys or books) Forgetting names
 Forgetting what you should be doing Forgetting where you are or where you are going
 Forgetting events that happened quite recently (e.g., last meal)
 Forgetting events that happened long ago (months or years)
 Needs someone to give a hint so you can remember
 Relying more and more on notes or reminders to remember things
 Forgetting the order of things (e.g., when putting something together, etc.)
 Other memory problems

9. BEHAVIOR AND EMOTIONAL FUNCTIONING

- | | | |
|--|---|---|
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Depression/sadness | <input type="checkbox"/> Recurrent/intrusive thoughts |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Overeating Weight gain |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Apathy | <input type="checkbox"/> Homicidal thoughts |
| <input type="checkbox"/> Anxiety/nervousness | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Recurrent/intrusive disturbing recollections or dreams |
| <input type="checkbox"/> Excessive fears or phobias | <input type="checkbox"/> Dependent | <input type="checkbox"/> Overwhelming need to perform certain behaviors/rituals |
| <input type="checkbox"/> Poor frustration tolerance | <input type="checkbox"/> Unmotivated | <input type="checkbox"/> Significant concerns with physical problems |
| <input type="checkbox"/> Explosive anger | <input type="checkbox"/> Rapid mood changes | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Feeling worthless | <input type="checkbox"/> Feelings of hopelessness | <input type="checkbox"/> Poor self-esteem |
| <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Anorexia or Bulimia | <input type="checkbox"/> Loss of interest in almost all activities |
| <input type="checkbox"/> Quiet | <input type="checkbox"/> Resists change | <input type="checkbox"/> Wetting bed or clothes |
| <input type="checkbox"/> Emotional | <input type="checkbox"/> Immature | <input type="checkbox"/> Bowel movements in underwear |
| <input type="checkbox"/> Is very fidgety | <input type="checkbox"/> Can't remain seated | <input type="checkbox"/> Can't wait your turn |
| <input type="checkbox"/> Is cruel to animals | <input type="checkbox"/> Destroys other people's property | |
| <input type="checkbox"/> Answers before you hears the whole question | | |
| <input type="checkbox"/> Other unusual behavior: _____ | | |

10. ACTIVITIES OF DAILY LIVING

- Difficulty dressing Difficulty bathing or showering Requires assistance for toileting
 Problems telling time Problems keeping track of time (i.e. resulting in missed or late arrival for work or classes)
 Unable to drive safely Unable to ride a bicycle safely in traffic
 Difficulty with grooming (including not attending to the same level of grooming as before)
 Difficulty with eating or feeding self independently, or not attending to table manners as before
 Unable to use of public transportation independently (i.e. school bus for children; city bus or taxi for and adult)
 Problems preparing a simple meal (i.e. sandwich) independently or using a microwave oven for frozen meals
 Problems preparing a complex meal (i.e. complete meal using the stove/oven) independently
 Difficulty preparing a list and shopping independently
 Problems handling cash purchases (i.e. making change)
 Problems writing checks or balancing a checkbook
 Difficulty managing household/personal finances
 Difficulty independently initiating or performing household chores

B. Medical History

Please check all the conditions that have been diagnosed as a child or an adult.

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS, ARC or HIV+ | <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Head injury or concussion | <input type="checkbox"/> Radiation exposure/therapy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hereditary disorder | <input type="checkbox"/> Senility (Dementia) |
| <input type="checkbox"/> Abscessed ears | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Immune system disease | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Huntington's disease |
| <input type="checkbox"/> Brain disease/infection | <input type="checkbox"/> Liver disorder | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Hormone problems |
| <input type="checkbox"/> Colds (excessive) | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Hazardous substance exposure |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Malnutrition |
| <input type="checkbox"/> Carbon monoxide poisoning | <input type="checkbox"/> Metabolic disorder | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Oxygen deprivation |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Enzyme deficiency | <input type="checkbox"/> Mumps | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Poisoning | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Fevers (104 or higher) | <input type="checkbox"/> Parkinson's Disease | |

Have you ever been diagnosed with epilepsy or a seizure disorder? Yes No If yes, please indicate which one:

PARTIAL: Simple partial (Jacksonian) Complex partial (Psychomotor) Partial evolving into generalized

GENERALIZED: Absence (Petit mal) Myoclonic Clonic Tonic Tonic-clonic (Grand mal) Atonic

UNCLASSIFIED TYPE

Other medical/physical problems _____

List any medications currently being taken (over-the-counter or prescription), and the dosage.

Medication and Dosage:

_____	_____
_____	_____
_____	_____

List any medications you are ALLERGIC or sensitive to: _____

Past Hospitalizations: (When, where, and for what)

Outpatient Surgeries: (When, where and for what)

C. Psychiatric History

Indicate which stressors you are experiencing currently (within the last 6 months) or in the past.

	Now	Past
Death of spouse		
Illness of friend		
Marital separation		
Conflicts with family		
New job		
Business difficulties		
Change in residence		
Incest/sexual abuse		
Other problems:		

Are you **currently** receiving therapy? _____ From who? _____

When did you start therapy? _____ For what problem(s)? _____

List current psychiatric medications: _____

Have you received therapy **in the past**? _____ From who? _____

When (Start and finish): _____ For what problem(s)? _____

List past psychiatric medications: _____

Have you been hospitalized for psychological problems? _____ When? _____

Where were you hospitalized? _____

Have you ever attempted suicide? _____ When? _____

How? _____

Circle substances you **currently** use (Even if only occasionally or in small amounts):

Alcohol Tobacco Marijuana Barbiturates ("Downers") Tranquilizers Amphetamines ("Speed") Crank Crack Cocaine
Opiates (Heroin, Opium, Codeine, etc.) Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) PCP ("angel dust")
Other: _____

Circle substances you have taken **in the past** (Even if only occasionally or in small amounts):

Alcohol Tobacco Marijuana Barbiturates ("Downers") Tranquilizers Amphetamines ("Speed") Crank Crack Cocaine
Opiates (Heroin, Opium, Codeine, etc.) Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) PCP ("angel dust")
Other: _____

Have you had a prior psychological or neuropsychological evaluation? Yes ___ No ___

If yes, complete this information:

Name of psychologist: _____

Address: _____ Phone: _____

Date of and reason for this evaluation: _____

Findings of the evaluation: _____

D. Birth and Developmental History

Place of Birth: _____ Were parents married at time of birth? _____

Was your mother under a doctor's care during the pregnancy? _____

Were you adopted? _____ If so, at what age? _____

Circle any illnesses during pregnancy: Anemia Toxemia Herpes Measles German measles Bleeding Kidney disease
Heart disease Hypertension Abdominal trauma Infection Diabetes

Medications taken during pregnancy: _____

Were drugs or alcohol taken during pregnancy? Yes ___ No ___ If yes, specify: _____

Was there significant emotional stress during pregnancy? Yes ___ No ___ If yes, name stressors: _____

Was the birth: ___ On time ___ Premature (By how long _____) ___ Late (By how long _____)

Was labor: ___ Spontaneous ___ Induced ___ Duration of labor _____ (Hours) Cesarean required? _____

Was the presentation: ___ Normal ___ Breach ___ Transverse (Crosswise) ___ Posterior first

Did the baby experience any of these problems:

___ Fetal distress ___ Prolapsed cord ___ Low placenta (Placenta previa)

___ Premature separation of the placenta (Abruptio placenta) ___ Cord wrapped around neck

___ Any other problems that mother or child had: _____

Was general anesthesia used? ___ Were forceps used? ___ Were there breathing problems? _____

Color at birth: ___ Normal ___ Blue ___ Yellow ___ Was oxygen used (How long)? _____ APGAR Score _____

Birthweight: _____ Length: _____

Circle those that apply to the first few weeks after birth:

Excessive sleeping Laziness Irritability Excessive crying Stiffness Limpness Tremors Twitching Feeding difficulties

Vomiting Jaundice Other _____

Transfusions required? ___ Medication required? (For what) _____

Surgery required? (For what) _____

Give approximate ages that developmental milestones were achieved:

Head control _____	Run _____	Toilet trained _____
Rolled over _____	Said first word _____	Dress self _____
Sat alone _____	Used sentences _____	Tie shoes _____
Walked _____	Self feeding with utensils _____	Color within lines _____

Circle any problems that occurred in later development:

Hearing Speaking Stuttering Reading Writing Spelling Arithmetic Behavior Hyperactivity Attentional difficulties
Seizures Coordination

List family members with developmental or learning problems: _____

E. Family History

Father's Name _____ Age _____
 Health Problems _____ Education _____
 Occupation _____ Employer _____

Mother's Name _____ Age _____
 Health Problems _____ Education _____
 Occupation _____ Employer _____

Date of parent's marriage _____ Years married _____ Current marital problems? _____
 If separated, give date _____ If divorced, date _____ Previous marriages? (Father) _____ (Mother) _____
 Subsequent marriages?(Father) _____ (Mother) _____

If divorced, current custody arrangement _____

Please provide information regarding step-parents if your parents are divorced:

Name	Age	Education	Occupation	Date Married	# Years
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Names and ages of brothers and sisters (Include step-brothers and step-sisters):

List anyone else who lived in the home during your childhood:

List names of any family members (E.G. Immediate and distant relatives) with any of the following problems:

Alcohol/drug abuse _____	Criminal history _____
Emotional/behavioral problems _____	Learning/developmental problems _____
Medical problems (e.g. Heart disease, Cancer, Seizures) _____	