

NEUROPSYCHOLOGY HISTORY FORM

Please fill out this form to the best of your knowledge. If some questions are not applicable to you, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet. Completing this form thoroughly will reduce interview time.

Form completed by: _____ Relationship to patient (if applicable): _____

Date form completed: _____

General Information

Patient's Name: _____ Gender: _____
First Middle Last

Date of Birth: _____ Age: _____ Ethnic/Cultural Background (optional) _____

Patient's Address:

_____ Number and Street City State Zip

Home phone: _____ Cell phone: _____ Work phone: _____

Occupation: _____ Retired: No Yes If yes, what date/year? _____

Primary Insurance _____ Policy/ID Number _____

Primary language spoken in the home: _____ Other language(s) spoken in the home: _____

Marital Status: Single Married (# yrs) _____ Committed relationship Widowed Separated Divorced

Number and ages of children: _____

Are children living with the patient? Yes No How many? _____

Patient lives: With spouse or partner/family Alone with assistance Alone with no assistance

Senior living community Assisted Living Nursing Home Other: _____

Emergency Contact Name: _____ Phone _____

Referral Information

Who referred you for a Neuropsychological evaluation? _____

Address of referral source: _____

Phone number of referral source: _____ Fax number of referral source: _____

Have you had a prior Neuropsychological Evaluation? Yes No

A copy of your report will be sent to the referral source and a copy will be placed in your electronic medical record. If you desire other persons to receive the report, Please request a release of information form.

Educational History

Highest grade completed? Less than High School (Last grade completed _____) GED Yes No
 High School Some college Associate's Bachelor's Graduate Degree (Specify: _____)

Identified learning disabilities (e.g. dyslexia, intellectual disability) or ADHD/ADD during school years?

Yes No If yes, please describe: _____

Special education? Yes No If yes, for what reason? _____

Any concern about possible difficulties that were not identified? Yes No If yes, describe: _____

Was the patient ever held back in school? Yes No What grade/s? _____

Why? _____

Current Concerns

Please describe the reason you/the patient was referred to our office: _____

Please mark any of the following difficulties you/patient experience/s on a day-to-day basis:

* Please note how long ago symptoms started (6 months, 1 year, 2 years, etc.) on the line provided after symptom(s)

- Forgetting things that happened recently _____
- Forgetting appointments _____
- Forgetting names of ___ friends ___ family _____
- Forgetting recent conversations _____

- Losing things more frequently _____
- Asking the same question(s) over and over _____
- Trouble remembering: the date ____ day of week ____ month ____ year _____
- Trouble remembering to take medications _____
- Forgetting daily routine (teeth, shaving, bathing, etc) _____
- Difficulty learning new things (cell phone, etc) _____
- Forgetting how to operate something that you knew in the past (remote, stove, washer, tools, computer, phone, etc) _____
- Mixed up/lost while driving or riding in car _____
- Confused in familiar places _____
- Harder to express thoughts or ideas to others _____
- Difficulty speaking/talking (slurring of words, mumbling) _____
- The “wrong” words come out _____
- Can’t quite “grab” the correct word _____
- Trouble recalling names of things _____
- Meaning of words is vanishing _____
- Can’t follow conversations as easily _____
- Need statements simplified due to poor comprehension _____
- Harder to follow a TV program/movie or book _____
- Difficulty concentrating or paying attention _____
- Harder to think through problems/make decisions _____
- Planning is harder (family meal, trip, projects) _____
- Harder to stay organized _____
- Harder deciding what is most important _____
- Making uncharacteristically poor decisions _____
- Writing difficulty (change over time) _____
- Difficulty spelling _____
- Not seeing things correctly/vision problems _____
- Reading difficulty (slowed, or ceased reading) _____
- Math difficulty (balancing checkbook, etc) _____

Problems in the following areas and duration: * Please check ALL of the problems observed

- Hygiene changes (difficulty bathing, styling hair, shaving, wearing clean clothing) _____
- Dressing (clothing choices or putting clothes on) _____
- Can't bathe/shower independently _____
- Can't use the bathroom independently _____
- Less safety awareness _____
- Cooking (leaving stove on, forgetting ingredients/recipes, etc.) _____
- Paying bills _____
- Managing money/Investments _____
- Performing household/yard chores _____
- Fender benders or accidents: _____ How many _____ How many months/years _____
- Grocery shopping _____
- Decreased driving (night, highways etc) _____
- No longer driving
- Emotional changes (irritable, sad, up and down, etc.) _____
- Saying or doing things that are uncharacteristic _____
- Sitting around more often/no motivation _____
- Personality changes (less patient, nicer, nastier, friendlier, eating more sweets, aloof, messy, not motivated) _____
- Decreased involvement in hobbies _____
- Not as outgoing or social _____
- Decline in social skills (rude, inappropriate, quiet, etc.) _____
- More likely to talk to strangers _____
- Compulsive behavior (spending, pornography, internet, Food, hobbies, gambling, etc.) _____
- Hoarding/buying unnecessary things _____

What year did you/the patient first notice problems? _____

What was your earliest symptom/change that concerned you? _____

What are you hoping to achieve with this evaluation? _____

Will any procedures conducted at our offices be part of an ongoing or planned legal case or disability case, and if so, please describe:

Services/Interventions Sought Previously for this Problem

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Medical lab Evaluation | <input type="checkbox"/> Neuropsychological Assessment | <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Neurological Exam |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Counseling or Therapy | <input type="checkbox"/> Speech Therapy | |

Has the patient had any of the following forms of psychological treatment? If so, how long did it last?

- | | | |
|------------------------------------|--|---------------------------------|
| Individual psychotherapy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Duration and date of therapy? |
| | | _____ |
| Inpatient mental health treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Duration and date of placement? |
| | | _____ |
| Suicide Attempts? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How many _____ |
| | | When? _____ |
| | | Method _____ |

Are you/the patient currently receiving psychological treatment? If so, with whom and how often?

Are you/the patient under the care of a psychiatrist? If so, with whom and how often?

Significant Stressors

Have there been any major changes within the family life or the patient's living situation that have affected the patient's functioning (e.g., deaths, moves, divorces, loss of job, etc)? No Yes (describe below)

Medical/Health History

Patient's primary physician _____ Phone Number _____

Vision problem? Yes No Hearing problem? Yes No

Decreased sense of smell/taste? Yes No

Difficulty swallowing Drooling Gagging Choking Difficulty Walking Dropping things?

Appetite concerns? Normal Decreased Increased Weight loss (lbs) _____ Weight gain (lbs) _____

Balance problems? Yes No How many falls: _____ In past: days _____ weeks _____ year(s) _____

Weakness? Yes No Where? _____

Tremors/Shaking? Yes No Body Part: _____ How Long? _____

Hearing or seeing things that are not there? Yes No How long? _____ How often? _____

Details: _____

Does the patient have problems falling asleep? Yes No Staying asleep? Yes No

Waking up during the night? Yes No If Yes, how many times per night typically? _____

Concerns related to toileting accidents or bowel/bladder incontinence or leaking Yes No

If yes, please describe: _____

MEDICATION HISTORY: (Use back of form or attach a sheet that includes medications)

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

MEDICAL HISTORY: (Use back of form if necessary or attach a list of medical problems)

Medical Problem	Date of Diagnosis	Description of problem. Please write on the back of this form if necessary

Surgeries: Age: _____ Reason: _____ Where: _____

Surgeries: Age: _____ Reason: _____ Where: _____

Hospitalizations: Age: _____ Reason: _____ Where: _____

Details: _____

Major accidents or injuries: Age: _____ Type (head, abdomen, fracture, etc.) _____

Details _____

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Details: _____

Has the patient ever been knocked unconscious? Yes No If yes, details and how long: _____

Has the patient ever been exposed to any toxic chemicals? Yes No If yes, please explain: _____

Has the patient had any of the following tests or evaluations?

	Yes	Date (month/year)	Where	Results
Neurological Evaluation				Normal Abnormal Don't Know
CT scan of head				Normal Abnormal Don't Know
MRI scan of head				Normal Abnormal Don't Know
EEG				Normal Abnormal Don't Know
Audiology or hearing evaluation				Normal Abnormal Don't Know
Vision evaluation				Normal Abnormal Don't Know
Genetic Testing				Normal Abnormal Don't Know
Other laboratory tests				Normal Abnormal Don't Know

Substance Use

How many alcoholic drinks a day/week does the patient consume and what kind? _____

At what age did patient start drinking? _____ When was the patient's last drink of alcohol? _____

Has the patient ever experienced problems due to alcohol consumption, and if so, please describe: _____

Is there a family problem of alcohol abuse, and if so, please describe: _____

Has the patient ever used any of the following?

Marijuana Heroin Cocaine/Crack LSD Ecstasy Methamphetamines Hallucinogens

Other non-prescribed drugs, please describe: _____

If the patient has used any of the above, please indicate frequency of use, age of first use, and describe any treatment: _____

Has the patient received any treatment for alcohol or other substance use? Yes No If yes, please describe: _____

Does the patient smoke cigarettes, pipes, cigars, or chew tobacco? Yes No
If yes, please describe frequency and amount: _____

Family Medical History

Have any of the patient's family members had the following problems/disorders? Please specify the family member's relationship to the patient and whether the relationship is on the maternal (m) or paternal (p) side. Example: aunt (p) = aunt on the father's side.

Family Member(s) Relation to Patient

Stroke/Aneurysm _____
Anxiety _____
Autism/ Asperger's _____
Birth defect _____
Dementia _____
Depression _____
Genetic disorder _____
Parkinson's Disease _____
Migraine headaches _____
Essential Tremor _____
Schizophrenia _____
Academic Problems _____
Other (specify): _____

Family Member(s) Relation to Patient

Alcohol/ Drug abuse _____
Attention Deficit Disorder _____
Bipolar disorder _____
Cancer _____
Memory Problems _____
Diabetes _____
Heart Disease _____
Mental retardation _____
Multiple sclerosis _____
Obsessive-Compulsive Disorder _____
Seizures or epilepsy _____
Tics/ Tourette's Disorder _____

Personal/Social Information

What are the patient's main hobbies and interests?

How often is the patient participating in these activities?

Has there been a decline in the patient's ability to do things that were once simple/easy? (home repairs, cooking, sewing, auto maintenance, etc)

Legal

Has the patient had any involvement with the legal system? Yes No

Is the patient currently on parole? Yes No Is the patient currently on probation? Yes No

Is there a lawsuit in relation to the problems for which you are being assessed? Yes No

Do you currently have a lawyer who you are discussing possible litigation with? Yes No
If yes, describe:

Are you currently involved in a Worker's Compensation case? Yes No

Previous Worker's Compensation history? Yes No If yes to either question, provide details:

Is the patient currently receiving disability? Yes No If yes, specify condition:

Is the patient currently applying for disability? Yes No If yes, specify condition:

Occupational History

Present or Most Recent Job (Include job titles, description of work, years employed):

Previous Jobs (job titles, description of work, years employed, and reason for change):

Any problems encountered in your current work activities?

Other Concerns

Please use this space to write in any additional concerns that were not addressed in this questionnaire.

The information I have provided is true and correct to the best of my knowledge:

Patient Signature (or POA)

Date