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ADULT NEUROPSYCHOLOGICAL HISTORY

Patient's Name: _____

Address (Street, City, State, Zip): _____

Telephone Number: (Home) (Work) (Other) _____

Age: Date of Birth: Sex: Education: _____

Primary Language: Secondary Language: _____

Hand used for writing: (check one) Right Hand: ☐ **Left Hand:** ☐

Foot used for kicking: (check one) Right Foot: ☐ **Left Foot:** ☐

Current Job Title/years in position: _____

Medical Diagnosis (if any):
(1.) _____
(2.) _____

Who referred you for this neuropsychological evaluation? _____

Briefly Describe the Problem: _____

_____

_____

When did the problem begin? _____

What specific questions would you like answered by this neuropsychological evaluation?:

1.)

2.)

3.)

4.)

SYMPTOM SURVEY

For each symptom that applies, place a check mark on the line. Add any helpful comments next to the line.

1.) PROBLEM SOLVING **Date of Onset**

	Difficulty figuring out how to do new things	
	Difficulty planning ahead	
	Difficulty figuring out problems that most other people can do	
	Difficulty thinking as quickly as needed	
	Difficulty doing things in the right order (sequence problems)	
	Difficulty verbally describing the steps involved in doing something	
	Difficulty changing a plan or activity in a reasonable amount of time	
	Difficulty completing an activity in a reasonable amount of time	
	Difficulty doing more than one this at a time	
	Difficulty switching from one activity to another activity	
	Easily frustrated	
	Other problem solving difficulties:	

2.) SPEECH, LANGUAGE, AND MATH SKILLS

	Difficulty finding the right word to say	
	Difficulty understanding what others are saying	
	Unable to speak	
	Difficulty staying with one idea	
	Difficulty writing letters or words (not due to motor problems)	
	Slurred Speech	
	Odd or unusual speech sound	
	Difficulty with math (e.g., checkbook balancing, making change, etc.)	
	Difficulty understanding what I read	
	Difficulty speaking	
	Other speech, language, or math problems:	

3.) NONVERBAL SKILLS

	Difficulty telling right from left	
	Difficulty doing things I should automatically be able to do (e.g., brushing teeth, etc.)	
	Problem drawing or copying	
	Difficulty dressing (not due to physical difficulty)	
	Problems finding my way around places I've been to before	
	Difficulty recognizing objects or people	
	Parts of my body do not seem as if they belong to me	
	Unaware of time (e.g., time of day, season, year)	
	Slow reaction to time	
	Other nonverbal problems:	

SYMPTOM SURVEY (continued)

4.) CONCENTRATION AND AWARENESS **Date of Onset**

☐	**Highly distractible**	
☐	**Lose my train of thought easily**	
☐	**Become easily confused and disoriented**	
☐	**Blackout spells (fainting)**	
☐	**My mind goes blank**	
☐	**Aura (strange feelings)**	
☐	**Don't feel very alert or aware of things**	
☐	**Other concentration or awareness problems:**	

5.) MEMORY

☐	**Forgetting where I leave things (e.g., keys, gloves, etc.)**	
☐	**Forgetting names**	
☐	**Forgetting what I should be doing**	
☐	**Forgetting where I am or where I am going**	
☐	**Forgetting events that happened quite recently (e.g., my last meal)**	
☐	**Need someone to give me a hint so I can remember things**	
☐	**Relying more and more on notes to remember how to do things**	
☐	**Forgetting how to do things, but I can remember facts**	
☐	**Forgetting faces of people I know (when they are not present)**	
☐	**Frequently forgetting appointments**	
☐	**Other memory problems:**	

6.) MOTOR AND COORDINATION **Check the side this occurs on:**

		Right side	Left side	Both Sides	Date of Onset
☐	**Fine motor control problems (e.g., using a pencil, key, etc.)**		☐	☐	☐
☐	**Weakness on one side of my body**		☐	☐	☐
☐	**Difficulty holding onto things**		☐	☐	☐
☐	**Tremor or shakiness**		☐	☐	☐
☐	**Muscle tick or strange movements**		☐	☐	☐
☐	**My writing is very small**				
☐	**My writing is very large**				
☐	**Walking more slowly than other people**				
☐	**Feeling stiff**				
☐	**Balance problems**				
☐	**Difficulty starting to move**				
☐	**Jerky muscles**				
☐	**Muscles tire quickly**				
☐	**Often bumping into things**				
☐	**Other motor or coordination problems:**				

SYMPTOM SURVEY (continued)

7.) SENSORY **Check the side this occurs on:**

		Right side	Left side	Both Sides	Date of Onset
☐	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		☐	☐	☐
☐	See “stars” or flashes of light		☐	☐	☐
☐	Double vision		☐	☐	☐
☐	Difficulty looking quickly from one object to another object				
☐	Need to squint or move closer to see clearly				
☐	Losing hearing				
☐	Ringing in my ears or hearing strange sounds				
☐	Difficulty tasting food				
☐	Difficulty smelling				
☐	Smelling strange odors				
☐	Other sensory problems:				

8.) PHYSICAL

☐	Headaches	
☐	Dizziness	
☐	Nausea or vomiting	
☐	Urinary incontinence	
☐	Loss of bowel control	
☐	Excessive tiredness	
☐	Sensitivity to bright lights	
☐	Sensitivity to loud noises	
☐	Other physical problems:	

9.) BEHAVIORAL/MOOD Check all that apply to you in the past 6 months

		Rate How Severe			
		Mild	Moderate	Severe	Date of Onset
☐	Sadness or depression		☐	☐	☐
☐	Anxiety or nervousness		☐	☐	☐
☐	Stress		☐	☐	☐
☐	Sleeping problems: (Falling Asleep ___ Staying Asleep ___)		☐	☐	☐
☐	Become more angry easily				
☐	Euphoria (feeling on top of the world)				
☐	Much more emotional (e.g., cry more easily)				
☐	Feel as if I just don’t care anymore				

SYMPTOM SURVEY (continued)

10.) BEHAVIORAL/MOOD (Continued) Check all that apply to you in the past 6 months

☐	**Doing things automatically (without awareness)**	
☐	**Less inhibited (to do things I would not do before)**	
☐	**Difficulty being spontaneous**	
☐	**Change in eating habits:**	
☐	**Change in interest in sex:**	
☐	**Loss of energy**	
☐	**Increase of energy**	
☐	**Experiencing nightmares on a daily/weekly basis**	
☐	**Loss of sexual desire**	
☐	**Increase in weight_____ Loss of weight_____**	
☐	**Lack of interest in pleasurable activities**	
☐	**Increase in irritability**	
☐	**Increase in aggression**	
☐	**Other recent changes in behavior or personality:**	

11.) Overall my symptoms have developed: _____ Slowly _____ Quickly

12.) My symptoms occur: _____ Occasionally _____ Often

13.) Over the past 6 months my symptoms have: _____Stayed the same _____ Worsened

14.) In summary there is: _____ Definitely something wrong with me.
_____ Possibly something wrong with me.
_____ Nothing wrong.

EARLY HISTORY (Complete all you can for this section)

15.) You were born: _____ On time _____ Prematurely _____ Late
16.) Your weight at birth: _____ lbs. _____ oz.
17.) Was there any problems associated with your birth (e.g., oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g., need of oxygen, special equipment used, convulsions, illness, etc.)? _____ Yes _____ No
18.) Check all that applied to your mother while she was pregnant with you:

☐	**Accident**
☐	**Alcohol use**
☐	**Cigarette smoking**
☐	**Drug use (marijuana, speed, cocaine, LSD, etc.)**
☐	**Illness (toxemia, diabetes, high blood pressure, infection, RH incompatibility, etc.)**
☐	**Poor nutrition**
☐	**Psychological problems**
☐	**Other problems:**

SYMPTOM SURVEY (continued)

19.) List all medications (prescribed or over the counter) your mother took while pregnant

_____

_____

20.) During her pregnancy, did your mother live near a polluted area (e.g., toxic waste dump) or other hazardous area (nuclear plant, industrial area, pesticide sprayed area, etc.)?

____ Yes _____ No If yes, describe: _____

21.) Rate your developmental progress as it has been reported to you, by checking one description of each area:

	Early	Average	Late
Walking		☐	☐
Language		☐	☐
Toilet training		☐	☐
Overall development		☐	☐

22.) As a child, did you have any of these conditions: (check all that apply)

☐	**Attentional problems**		**Head Injury**
☐	**Clumsiness**		**Hearing problems**
☐	**Developmental delay**		**Hyperactivity**
☐	**Learning disability**		**Frequent ear infection**
☐	**Speech problems**		**Vision problems**
☐	**Muscle tightness or weakness**		**Depression**
☐	**Loss of consciousness**		
☐	**Other psychiatric difficulty:**		
☐	**Other problems:**		

MEDICAL HISTORY

CHILDHOOD MEDICAL HISTORY

23.) Check all the conditions that were diagnosed when you were a child. Add any helpful details (age at diagnosis, treatment, provided, etc.):

☐	**Allergies**		**Epilepsy or seizures**		**Pnuemonia**
☐	**Scarlet fever**		**Heart Problems**		**Fevers (104^0F or higher)**
☐	**Brain infection or disease**		**Immune system disease**		**Poisoning**
☐	**Rheumatic fever**		**Kidney problems**		**Polio**
☐	**Cerebral palsy**		**Lung (respiratory problems)**		**Cancer**
☐	**Chicken pox**		**Venereal disease**		**Asthma**
☐	**Colds (excessive)**		**Whooping Cough**		**Diabetes**
☐	**Oxygen deprivation**		**Tuberculosis**		**Measles**
☐	**Meningitis**		**Encephalitis**		
☐	**Other disease or disabilities:**				

SYMPTOM SURVEY (continued)

24.) As a child, were you exposed to excessive amounts of lead (e.g., eating pint chips, living next to high concentrations of automobile exhaust fumes, etc.)? _____ Yes _____ No
If yes, explain:_____

25.) As a child, did you have an accident which required a hospital visit: _____ Yes _____ No
If yes, describe what happened:_____
_____

26.) Did you ever suffer a serious injury to your head? _____ Yes _____ No
If yes, explain the circumstances and any problems you had afterwards:
_____
_____
_____

27.) How would you describe your nutrition as a child and adolescent?
_____ Excellent _____ Average _____ Poor

28.) List the medications that were regularly given to you as a child:

Medication	Reason for Medication
1.	
2.	
3.	
4.	
5.	

ADULT MEDICAL HISTORY

29.) Check all that apply:

☐	**AIDS, ARC, or HIV+**		**Heart Disease**
☐	**Allergies**		**Huntington's Disease**
☐	**Arteriosclerosis (artery disease)**		**Hypertension**
☐	**Arthritis**		**Kidney Disease**
☐	**Blood Disease**		**Liver Disease**
☐	**Brain Disease**		**Loss of consciousness**
☐	**Cancer or chemotherapy**		**Lung (respiratory) Disease**
☐	**Parkinson's Disease**		**Malnutrition**
☐	**Psychiatric problems**		**Meningitis**
☐	**Senility (dementia)**		**Multiple Sclerosis**
☐	**Venereal Disease**		**Polio**
☐	**Hazardous substance exposure**		**Radiation exposure or therapy**
☐	**Thyroid Disease**		**Severe Snoring/Sleep Apnea**
☐	**Any other problems:**		

MEDICAL HISTORY (continued)

30.) List any medications you currently take (over the counter or prescription medication), and the dosage.

Medication	Dosage
1.	
2.	
3.	
4.	
5.	

31.) Do you have epilepsy or seizure disorder? _____ Yes _____ No
If yes, check the one you have been diagnosed with:

PARTIAL **GENERALIZED** **_____ UNCLASIFIED TYPE**

☐	Simple partial (Jacksonian)	☐	Absence (Petit small)
☐	Complex partial (psychomotor)	☐	Myoclonic
☐	Partial evolving into generalized	☐	Clonic
		☐	Tonic
		☐	Atonic
		☐	Tonic-clonic (Grand mall)
☐	I have a Seizure Disorder but I don't know which type. Please describe it:		

32.) Are you currently in psychotherapy or under psychiatric care? _____ Yes _____ No

33.) Have you ever been in psychotherapy or under psychiatric care? _____ Yes _____ No
If yes, please list date(s) of therapy and name(s) of professional(s) who treated you.

_____
_____
_____
_____

34.) Have you ever been prescribed medications for a mental or nervous condition (e.g., anti-anxiety medication, anti-depressants, major tranquilizer? _____ Yes _____ No

35.) Please list all inpatient hospitalizations including the name of the hospital, date of hospitalization, duration of hospitalization, and diagnosis.

_____
_____
_____
_____
_____
_____

SUBSTANCE USE HISTORY

ALCOHOL

36.) I started drinking regularly at age:
Less that 10 years old _____, 10-15 _____, 16-18 _____, 19-21 _____, over 21 _____

37.) I drink alcohol:

☐	**Rarely or never**		**1-2 days/week**
☐	**3-5 days/week**		**daily**

38.) Preferred type(s) of drinks: _____

39.) Usual numbers of drinks I have at one time: _____

40.) My last drink was:

☐	**Less than 24 hours ago**		**24-48 hours ago**		**Over 48 hours ago**

41.) Check all that apply:

☐	**I can drink more than most people my age and size before I get drunk.**
☐	**I sometimes get into trouble (fights, legal difficulty, problems at work, conflicts with family, accident, etc.) after drinking.**
☐	**I sometimes blackout after drinking.**

42.) Please check all the drugs you are now using or have used in the past:

		Presently Using	**Used in the Past**
☐	**Amphetamines (including diet pills)**		
☐	**Barbiturates (downers, etc.)**		
☐	**Cocaine or crack**		
☐	**Hallucinogenics (LSC, acid, STP, etc.)**		
☐	**Inhalants (glue, nitrous oxide, etc.)**		
☐	**Marijuana**		
☐	**Opiate Narcotics (heroin, morphine, etc.)**		
☐	**PCP (or "angel dust")**		
☐	**Please list all other drugs:**		

43.) Do you consider yourself dependent on any of the above drugs? _____ Yes _____ No
If yes, which one(s):_____

44.) Do you consider yourself dependent on any prescription drugs? _____ Yes _____ No
If yes, which one(s):_____

45.) Check all that apply:

☐	**I have gone through drug withdrawal**
☐	**I have used I.V. drugs**
☐	**I have been in drug treatment**

SUBSTANCE USE HISTORY (continued)

46.) Do you smoke? _____ Yes _____ No
If yes, amount per day: _____

47.) Do you drink coffee? _____ Yes _____ No
If yes, amount per day: _____

FAMILY HISTORY

The following questions deal with your biological mother, father, brothers and sisters:

MOTHER

48.) Is she alive? _____ Yes ____ No If deceased, what was the cause of her death?
_____

49.) Mother's occupation: _____

50.) Mother's highest level of education: _____

51.) Does your mother have a known or suspected learning disability? _____ Yes ____ No

FATHER

52.) Is he alive? _____ Yes ____ No If deceased, what was the cause of his death?
_____

53.) Father's occupation: _____

54.) Father's highest level of education: _____

55.) Does your father have a known or suspected learning disability? _____ Yes ____ No

56.) How many brothers and sisters do you have? _____
What are their ages? _____

57.) Are there any unusual problems (physical, academic, psychological) associated with any of your brothers or sisters? If yes, please describe: _____
_____

58.) How many children do you have?

	Boys	**Age(s)**	
	Girls	**Age(s)**	

59.) Any problems (physical, academic, psychological) associated with any of your children?
_____ Yes _____ No
If yes, describe: _____
_____

FAMILY HISTORY (continued)

60.) Please check all that existed in close biological family members (parents, brothers, sisters, grandparents, aunts, uncles), note who it was and describe the problem where indicated.

		Who?
☐	**Epilepsy or seizures**	
☐	**Mental Retardation**	
☐	**Attention Deficit/Hyperactivity Disorder (ADD/ADHD)**	
☐	**Learning Disability or "dyslexia"**	
☐	**High Blood Pressure**	
☐	**Heart Disease**	
☐	**Stroke**	

Neurologic (brain) Disease:

☐	**Alzheimer's Disease**	
☐	**Huntington's Disease**	
☐	**Multiple Sclerosis**	
☐	**Parkinson's Disease**	

☐	**Other Neurologic Disease**	
	Describe:	

Psychiatric Illness:

☐	**Alcoholism**	
☐	**Bipolar Illness (manic depression)**	
☐	**Depression**	
☐	**Schizophrenia**	
☐	**Other Psychiatric Illness**	
	Describe:	
☐	**Speech or Language Disorder**	
	Describe:	
☐	**Other Major Disease or Disorder**	
	Describe:	

PERSONAL HISTORY

MARITAL STATUS

61.) Current marital status: Married ___, Single ___, Divorced ___, Widowed ___, Separated ____

62.) Years married to current spouse: _____

63.) Number of times married? _____

64.) Spouse's name: _____ Age: _____

65.) Spouse's occupation: _____

66.) Spouse's health: _____ Excellent _____ Good _____ Poor

67.) Not married, but living with someone: _____ Yes _____ No
His/Her Age: _____ His/Her Name: _____

EDUCATIONAL HISTORY

68.) Highest grade or degree you've earned: _____

69.) How would you describe your usual performances as a student:

☐	**A & B**
☐	**B & C**
☐	**C & D**
☐	**D & F**

Please provide any additional helpful comments about your academic performance:

70.) What was your best subject(s)? _____
What was your weakest subject (s)? _____

71.) Were you ever held back to repeat a grade? _____ Yes _____ No
If yes, what grade (s)? _____ Reason? _____

72.) Were you ever in any special class(es) or received special services? _____ Yes _____ No
If yes, what grade? _____Or age? _____
What type of class? _____

OCCUPATIONAL HISTORY

73.) Current job title: _____

74.) Salary:

☐	**Under $10,000.00**		**$10,000.00 - $29,900.00**
☐	**$30,000.00 - $50,000.00**		**Over $50,000.00**

75.) How long have you been on this job? _____

76.) Current job responsibilities: _____

OCCUPATIONAL HISTORY (continued)

77.) Prior jobs: Start with most recent:

a.
b.
v.
d.

78.) At any time on a job, were you exposed to toxic, hazardous, noxious, or otherwise dangerous or unusual substances (e.g., lead, mercury, radiation, solvents, pesticides, chemicals, etc.)?
_____ Yes _____ No
If yes, explain: _____
_____
_____

MILITARY HISTORY

79.) Branch: _____

80.) Discharge rank: _____ Type of Discharge: _____

81.) Major military duties: _____

82.) Did you sustain any physical injuries in the military? _____ Yes _____ No
If yes, describe: _____
_____
_____

83.) Were you ever exposed to any dangerous or unusual substances during your service (e.g., Agent Orange, radiation, etc.)? _____ Yes _____ No
If yes, describe: _____
_____
_____

RECREATION

84.) Briefly list the types of recreation (sports, games, TV, hobbies, etc.) that you enjoy:
_____
_____
_____
_____

MEDICAL TESTING

85.) Check all the medical tests that recently have been done and report any abnormal findings:

		Check here if Normal	**Abnormal Findings**
☐	**Angiography**		
☐	**Blood work**		
☐	**Brain Spect**		

☐	**CT Scan**		

☐	**EEG**		
☐	**Lumbar puncture or spinal tap**		
☐	**(MRI) Magnetic Resonance Imaging**		
☐	**Neurological Office Exam**		
☐	**Physician's Office Exam**		

85.) Check all the medical tests that recently have been done and report any abnormal findings:

	(continue)	**Check here if Normal**	**Abnormal Findings**
☐	**Skull x-ray**		
☐	**Ultrasound**		
☐	**Other testing:**		

86.) Identify the physician who is most familiar with your recent problems:

Name of Physician: _____

Address: _____

_____

_____

Phone:_____ Fax: _____Other:_____

Date of last medical check up: _____

Findings of last check up: _____

_____

_____

_____

_____

Date of last vision exam: _____

Date of last hearing exam: _____

87.) Have you had a prior psychological on neuropsychological evaluation? _____ Yes _____ No

If yes, complete this information:

Name of Psychologist:_____

Address: _____

_____

_____

Phone:_____ Fax: _____Other:_____

Date of and reason for evaluation: _____

Findings of the evaluation:_____

_____

_____

_____

_____