THE NEUROPSYCHOLOGY CONSULTANTS

Neuropsychological Evaluation, Neurobehavioral Management, Forensic Neuropsychology, Clinical Psychology
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ADULT NEUROPSYCHOLOGICAL HISTORY: Please answer all of the following questions as accurately as possible.

Today's Date_____

Person Completing Form_____ Relationship to Patient_____

Phone (home)_____ Phone (work)_____

Patient's Name_____ Date of Birth_____

Address_____
Street City State Zip

Guardians' Name (if applicable) _____

Home Phone #_____ Work Phone_____

Date of Birth_____ Age_____ Sex_____ Social Security # _____-_____-_____

Highest Education Completed_____

Primary language_____ Secondary language_____

Left handed_____ Right handed_____ Ambidextrous_____

Ethnic or racial background_____ Religion_____

Who referred you for this evaluation?_____

Briefly describe the problem: _____
_____

What specific questions would you like answered by this evaluation?

1)_____

2)_____

3)_____

NEUROPSYCHOLOGICAL SYMPTOM CHECKLIST:

Are you currently under a doctor's care? Yes_____ No_____ If yes, Dr.'s name_____

What is this doctor treating you for?_____

If no-who is your family doctor?_____

How long since you last checkup?_____

Below is a list of questions about your health and health habits. Please think very carefully and check every problem that applies. If you are not sure what the questions means or not sure of your answer just draw a circle around the question and the doctor will help you with it later. Just be sure to answer every question.

Have you had…	YES	NO	Describe
Loss of sense of smell			
Change in sense of smell			
Smell of bad odors			
Loss of sense of taste			
Change in sense of taste			
Bad tastes			

Are you…	YES	NO	Describe
Blind in the left eye			
Blind in the right eye			
Blind in both eyes			

Do you…	YES	NO	Describe
Wear glasses			
Wear contact lenses			

Have you had…	YES	NO	Describe
Blurred vision			
Double vision			
Loss of vision			
Blank spots in vision			
Flashing lights in vision			

Are you…	YES	NO	Describe
Deaf in left ear			
Deaf in right ear			
Deaf in both ears			

Do you…	YES	NO	Describe
Wear a hearing aid			

Have you had…	YES	NO	Describe
Loss of hearing			
Ringing in the ears			

Have you had…	YES	NO	Describe
Any paralysis			
Muscle weakness			
Muscle twitching			
Muscle spasms			
Trouble walking			
Coordination problems			

Balance problems			
Tremors or shakiness			
Problems with dropping items			

Have you had…	YES	NO	Describe
Numbness			
“Tingling” skin			
“Pins and needles”			
Burning skin			
Loss of feeling			
Loss of telling hot from cold			
Changes in skin			

Do you have…	YES	NO	Describe
Pain			
Headaches			

Have you had…	YES	NO	Describe
Black-out spells			
Seizures or fits			
Fainting spells			
Periods where you “lose” time			

Do you…	YES	NO	Describe
Get lost often			
Forget where you are			
Forget time and day			
Forget meetings			
Have memory problems			

Do you…	YES	NO	Describe
Hear unusual sounds			
See unusual things			
Have strange feelings			

Does it seem that you…	YES	NO	Describe
Can’t think as quickly as before			
Find it hard to think clearly			
Are more easily distracted			
Can’t concentrate			
Have trouble with “common sense”			

Have you had trouble…	YES	NO	Describe
Using tools			
Telling right from left			
Getting dressed			
Remembering the right word when talking			

Understanding others			
Following conversation			
With your speech			
With reading			
With writing			

Have you had problems with…	YES	NO	Describe
Sadness or depression			
Stress, tension, or anxiety			
Anger or keeping your temper			
Worry or guilt			
Change in your attitudes			
Loss of interest			

Have you had…	YES	NO	Describe
Childhood diseases or injuries			
Head injuries			
Problems with nerves			
High fevers			
Serious infections			
Diabetes			
Liver problems			
Kidney problems			
Problems with arteries			
A stroke			
Hypertension			
Heart problems			
Blood problems			
Cancer			

Have you had…	YES	NO	Describe
Surgery			

If yes, for what_____

_____

Do you…	YES	NO	Describe
Drink alcohol			
Smoke tobacco			
Take prescribed or over the counter medications			
Work with chemicals			

Are there…	YES	NO	Describe
Any family members with history of serious illness			

If there are any symptoms that you have which have not been asked about on this form please describe below:

_____
_____
_____

EARLY HISTORY:

You were born: On time_____ Prematurely_____ Late_____

Your weight at birth: _____lbs. _____oz.

Mother's weight gain during pregnancy: _____lbs.

Were there any problems associated with your birth (e.g., oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g., need for oxygen, special equipment used, convulsions, illness, etc.)? If yes, please describe: _____
_____

Check all that applied to your mother while she was pregnant with you:

_____Accident
_____Alcohol use
_____Cigarette smoking
_____Drug use
_____Illness
_____Poor nutrition
_____Psychological problems
_____Other problems:_____

Rate your developmental progress as it has been reported to you by checking one description for each area:

	Early	Late	Average
Walking			
Language			
Toilet training			
Overall development			

As a child, did you have any of these conditions? (Check all that apply)

	YES	NO	Describe
Attention problems			
Clumsiness			
Developmental delay			
Frequent ear infections			
Head injury			
Hearing problems			
Hyperactivity			
Learning disability			
Muscle tightness or weakness			
Speech problems			
Vision problems			
Other problems			

CHILDHOOD MEDICAL HISTORY:

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

_____Allergies
_____Asthma
_____Brain infection or disease
_____Cancer
_____Cerebral palsy
_____Chicken pox
_____Colds (excessive)
_____Diabetes
_____Encephalitis
_____Epilepsy or seizures
_____Fevers (104 F or higher)
_____Heart problems
_____Immune system disease
_____Kidney problems
_____Lung/respiratory disease
_____Measles
_____Meningitis
_____Oxygen deprivation
_____Pneumonia
_____Poisoning
_____Polio
_____Rheumatic fever
_____Scarlet fever
_____Tuberculosis
_____Venereal disease
_____Whooping cough

_____Other diseases or disabilities:_____
_____

As a child were you exposed to excessive amounts of lead (e.g., eating paint chips, living next to high concentrations of automobile exhaust fumes, etc.)? If yes, please explain: _____
_____

As a child, did you have an accident which required a hospital visit? If yes, please explain: _____
_____

Did you ever suffer a serious injury to your head? If yes, please explain: _____
_____

How would you describe your nutrition as a child and adolescent? _____Excellent _____Average _____Poor

List the medications and reason for their use that you were given regularly as a child:

1)_____ 2)_____ 3)_____ 4)_____

ADULT MEDICAL HISTORY:

Check all the conditions that currently apply.

_____AIDS, ARC, or HIV
_____Allergies
_____Heart disease
_____Huntington's disease
_____Parkinson's disease
_____Polio

_____Arteriosclerosis _____Hypertension _____Psychiatric problems

_____Arthritis _____Kidney disease _____Radiation exposure

_____Blood disorder _____Liver disease _____Senility (dementia)

_____Brain disease or infection _____Lung/respiratory disease _____Stroke or TIA

_____Cancer or chemotherapy _____Malnutrition _____Thyroid disease

_____Diabetes _____Meningitis _____Venereal disease

_____Hazardous substance exposure _____Multiple sclerosis

_____Any other problems:_____
_____

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

1)_____

2)_____

3)_____

Do you have epilepsy or a seizure disorder? _____Yes _____No

If yes, check the one you have been diagnosed with:

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

_____I HAVE A SEIZURE DISORDER BUT DON'T KNOW WHICH TYPE

Describe all of the hospitalizations you have had:

1)_____

2)_____

3)_____

FAMILY HISTORY:

MOTHER
What is your mother's name (include maiden name)?_____

Is she alive? Yes_____ No_____ If deceased, what was the cause of death?_____

Mother's occupation:_____ Mother's level of education:_____

Does your mother have a known or suspected learning disability? Yes_____ No_____

Briefly describe your mother's health history: _____

FATHER
What is your father's name?_____

Is he alive? Yes_____ No_____ If deceased, what was the cause of death?_____

Father's occupation: _____ Father's level of education:_____

Does your father have a known or suspected learning disability? Yes_____ No_____

Briefly describe your father's health history: _____

When you were born, what was your mother's age?_____ Father's age?_____

How many brothers and sisters do you have?_____

Where are you in the birth order?_____

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

Who raised you?

_____Biological parents _____Relatives _____Foster parents

_____Biological parent plus other person _____Adoptive parents' _____Institutional setting

_____Others Who?_____

What languages were spoken at home when you were a child?_____Primary _____Secondary

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 seizure	_____
_____Learning disability	_____
_____Left-handedness	_____
_____Mental retardation	_____

Neurologic (brain disease)

_____Alzheimer's disease or senility	_____
_____Huntington's disease	_____
_____Multiple sclerosis	_____
_____Parkinson's disease	_____
_____Other neurologic disease	_____

Psychiatric illness

_____Alcoholism	_____
_____Bipolar illness (manic depression)	_____
_____Depression	_____
_____Personality disorder	_____
_____Schizophrenia	_____
_____Other psychiatric illness	_____

Other

_____Speech or language disorder

_____Other major disease or disorder

PERSONAL HISTORY:

Marital history

Current marital status: Married_____ Single_____ Divorced_____ Widowed_____ Separated_____

Years married to current spouse: _____

Number of times married: _____

Spouse's name: _____ Spouse's age: _____

Spouse's occupation: _____

Spouse's health: Excellent_____ Good_____ Poor_____

Not married, but living with someone: Yes_____ No_____

His/her health: Excellent_____ Good_____ Poor_____

His/her occupation: _____

Educational history

Highest grade or degree earned: _____

How would you describe your usual performance as a student?

_____A & B

_____B & C

_____C & D

_____D & F

Please provide any additional helpful comments about your academic performance: _____
_____

What was your best subject(s)?_____ Weakest subject(s)?_____

Where you ever held back to repeat a grade? Yes_____ No_____

If yes, what grade(s)?_____ And reason: _____

Were you ever in any special class(es) or received special services? Yes_____ No_____

If yes, what grade?_____ Or age?_____ And what type of class?_____

Occupational history

Current job title: _____

Salary: Under $10,000_____ $10,000-29,999_____ $30,000-$50,000_____ Over $50,000_____

How long have you been on this job?_____

Current responsibilities: _____
_____

Prior jobs (start with most recent and include time on the job):

1)_____

2)_____

3)_____

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, please explain: _____

Military history

Branch: _____

Discharge rank: _____ Type of discharge: _____

Major military duties: _____

Did you sustain any physical injuries in the military? Yes_____ No_____

If yes, please describe: _____

Where you ever exposed to any dangerous or unusual substances during your service (e.g., Agent Orange, radiation, etc.)? Yes_____ No_____

If yes, please explain: _____

Recreation

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

SUBSTANCE ABUSE HISTORY:

Alcohol

I started drinking at age: _____less than 10 years _____10-15 _____16-18 _____19-21 _____over 21

I drink alcohol: _____rarely or never _____1-2 days/week _____3-5 days/week _____Daily

I used to drink but have stopped: Yes_____ No_____ Date stopped:_____

Preferred type(s) of drinks: _____

Usual number of drinks I have at a time: _____

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, accidents, etc.) after drinking.

_____I sometimes blackout after drinking.

Drugs

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

	Presently using	Used in the past
_____Amphetamines (include diet pills)	___	___
_____Barbiturates (downers)	___	___
_____Cocaine or Crack	___	___
_____Hallucinogenics (LSD, acid)	___	___
_____Inhalants (glue, nitrous oxide)	___	___
_____Marijuana	___	___
_____Opiate narcotics (heroin, morphine)	___	___
_____PCP (angel dust)	___	___

Please list any other drugs and indicate if you currently use or have used in the past: _____
_____

Do you consider yourself dependent on any of the above drugs? _____Yes _____No

If yes, which one(s)?_____

Do you consider yourself dependent on any prescription drugs? _____Yes _____No

If yes, which one(s)?_____

Check all that apply:

_____I have gone through drug withdrawal.

_____I have used IV drugs.

_____I have been in a drug treatment program.

MEDICAL TESTING:

Check all the medical tests that recently have been done and report any abnormal finding:

	Check here if normal	Abnormal findings
_____Angiography	___	_____
_____Blood work	___	_____
_____Brain scan	___	_____
_____CT scan	___	_____
_____EEG	___	_____
_____Lumbar puncture or spinal tap	___	_____
_____Magnetic Resonance Imaging (MRI)	___	_____
_____Neurological office exam	___	_____
_____PET scan	___	_____
_____Physicians office exam	___	_____
_____Skull X-ray	___	_____
_____Ultrasound	___	_____
_____Other testing	___	_____

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

Name of physician: _____

Address: _____

Phone: _____

Date of your last medical check-up: _____

Findings of your last medical check-up: _____

Have you had a prior psychological or neuropsychological evaluation? _____Yes _____No

If yes, complete this information:

Name of psychologist: _____

Address: _____

Phone: _____

Date and reason for this evaluation: _____

Findings of the evaluation: _____

THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE.