ADULT NEUROPSYCHOLOGICAL HISTORY

Person completing this form: Patient ___ Spouse _____ Parent _____ Other _____

Patient's Name: _____ Date: _____

Date of Birth: _____ Age: __ Sex: ___ Race: _____ Marital Status: _____

Address: _____ SS#: _____

Phone #s: Home: _____ Work: _____ Cell: _____

Injured while working? (Workers' Comp) No ____ Yes ___ Date of Injury _____

Injured in accident? No _____ Yes ___ Cause _____ Date _____

Applying/Applied for Disability? No ____ Yes ___ Granted? _____ Denied? _____ Date _____

Symptom History

Specific cognitive problems (attention or memory problems, etc.)? No __ Yes ___ (please describe)

When did these problems begin?_____

Did they begin: Abruptly _____ Gradually _____

Have they gotten: Better _____ Worse _____ Stayed the Same _____

Have you or others noticed changes in your:

Speech? No ____ Yes ___ (explain) _____

Appearance? No _____ Yes ___ (explain) _____

Mood or personality? No _____ Yes ___ (explain) _____

Movements or motor functioning? No __ Yes ___ (explain) _____

_____

Medical History:

Do you know if your mother had any difficulty during her pregnancy with you?

No ____ Unknown _____ Yes ___ (explain) _____

Were you born prematurely or were there any complications at the time of your birth?

No ____ Unknown _____ Yes ___ (explain) _____

Were there any problems with your development during childhood? No _____ Unknown _____ Yes ___

(explain) _____

Please note in the space below major medical illnesses, injuries, and hospitalizations, with age at time of event:

Additionally, have you ever had?

Hearing problems No ____ Yes ___ Age ___

Tremors/Shakiness No ____ Yes ___ Age ___

Dizziness No ____ Yes ___ Age ___

Cigarette smoking No ____ Yes ___ Age ___

Seizures No ____ Yes ___ Age ___ Explain: _____

Frequent falling No ____ Yes ___ Age ___ Explain: _____

Sleep problems No ____ Yes ___ Age ___

Injured arms/hands No ____ Yes ___ Age ___

Other: _____

Hand you write with: _____

If you ever had head injuries (i.e., concussion, brain injury, etc.), complete below:

Age at the time of the first head injury: _____ Do you remember the actual event? No _____ Yes ___

Describe the head injury: _____

_____

_____

Did you lose consciousness? No Yes ___ Length of unconsciousness: _____

What was your last clear memory before the injury? _____

What was your first clear memory after the injury? _____

Describe any medical treatment/medication you received in relation to the head injury:

_____

List any physical symptoms you had following the head injury (such as vomiting, blurred vision, or headache):

_____

If you have additional head injuries, please describe them as above, using the reverse side of these pages.

Medications

Current medication(s) with dosage (if known):

Mental health medications prescribed in the past:

Substance Use

Do you currently use tobacco? No _____ Yes ___

If yes, specify the type and quantity per day: _____

How long have you used tobacco? _____

If you currently do not use tobacco, but have in the past, describe how much and how long you used tobacco:

Do you currently drink alcohol? No _____ Yes ___

If yes, specify the type and number of drinks per day or per week: _____

For how long (since what age)? _____

If you currently do not drink alcohol, but did in the past, describe how much and how long you drank in the past: _____

Have you ever tried or taken recreational or street drugs? No ___ Yes ___

If yes, please list them, try to include quantity and frequency:

_____

_____

Mental Health

Have you ever experienced significant anxiety, depression, suicidal or homicidal feelings or attempts in the past or presently? No _____ Yes _____ (explain below)

Please note in the space below any other mental health conditions, treatments, and hospitalizations, with age at time of event:

Family Medical/Social History

Please list the people currently living you, including sex, ages, and relationship:

Mother's highest level of education: _____ Occupation: _____

- Medical/Psychiatric Problems: _____

Father's highest level of education: _____ Occupation: _____

- Medical/Psychiatric Problems: _____

Number of Siblings: _____

- Medical/Psychiatric Problems: _____

Educational History

Skipped any grades? No _____ Yes ___ (explain) _____

Repeated any grades? No _____ Yes ___ (explain) _____

Special education classes, tutoring, or alternative school placement (if any): _____

Easiest subjects: _____Difficult subjects: _____

Your highest grade completed: _____ GED?: _____

Typical grades in elementary school: _____

Diagnosed learning or attention disorders? ? No Yes ___ (if yes explain)

_____

College or University Education: No ____ Yes ___) SAT/ACT or similar scores? _____

Degree: _____ Major/Area: _____

Institution Name: _____ Location: _____

Typical Grades or GPA: _____

Technical or Vocational Training (if any): _____

Typical Grades on Report Card: _____

Employment History

Are you currently employed?

No ____ How long? _____ Reason for unemployment: _____

Yes ____ How long at your present job? _____ Job title: _____

Significant prior jobs: _____

Have you ever served in the military? No _____ Yes ___ Combat experience ? No _____ Yes _____

If yes, what branch of the military were you in? _____ Years served: _____

Highest Rank/position: _____ Type of Discharge: _____

Legal History

Have you ever been incarcerated? No __ Yes ___ (explain) _____

Are you currently involved, or planning to become involved, in any civil litigation related to your symptoms"

No ____ Yes ___

Are you represented by an attorney? No _____ Yes ___ (name) _____