ADULT NEUROPSYCHOLOGY HISTORY
NEURORESOURCES, PLLC.

NAME: _____ DATE: _____

ADDRESS: _____ DATE OF BIRTH: _____

_____ HANDEDNESS(circle one):

TELEPHONE: _____ Right Left Ambidextrous

REFERRAL SOURCE: _____ EDUCATION: _____ years

_____ OCCUPATION: _____

MARITAL STATUS (circle one): Single Married ETHNICITY: _____

Divorced Remarried Widowed Separated

THIS FORM WAS COMPLETED IN WHOLE, OR IN PART, BY: _____
RELATION TO PATIENT _____

PRESENT PROBLEM/REASON FOR EVALUATION:

_____
_____
_____
_____
_____

Date of Illness/Injury/Onset _____

DEVELOPMENTAL HISTORY:

PLACE OF BIRTH: _____

Birth Complications:

_____ Low Birth Weight
_____ Oxygen Deprivation
_____ Premature
_____ Deformity (specify) _____
_____ Illness (specify) _____
_____ Birth Trauma

Developmental Milestones (approximate age in months):

_____ Standing
_____ Bedwetting
_____ Potty Trained
_____ Talking
_____ Walking

Childhood Diseases/Surgeries:

_____ Loss of Consciousness
_____ Concussion
_____ Tonsillectomy
_____ Convulsions
_____ Encephalitis
_____ Meningitis
_____ High Fever (over 104° F)
_____ Pneumonia
_____ Allergies
_____ Asthma/Bronchitis
_____ Cancer
_____ Seizure
_____ Oxygen Deprivation or Near Drowning
_____ Accidental Poisoning (specify substance)
_____ Appendectomy
_____ Cerebral Palsy
_____ Multiple Sclerosis
_____ Cut Requiring Stitches
_____ Broken Bones
_____ Other _____

EDUCATIONAL HISTORY:

Special Education Classes: Yes No
If yes, classes were for _____

Learning Disabilities:
_____ Reading _____ Other (specify) _____
_____ Spelling _____ Favorite Subject
_____ Math _____ Least Favorite Subject

Schools Attended:		Dates Attended:	Degree Obtained:
High School	_____	_____	_____
College	_____	_____	_____
Vo-Tech During HS	_____	_____	_____
Vo Tech After HS	_____	_____	_____
GED	_____	_____	_____

Overall Grades Obtained:
_____ High School _____ College (GPA)
_____ Vocational/Technical _____ Major

OCCUPATIONAL HISTORY: (Please list most current jobs first and then past jobs.)

Job	Employer	Approximate Dates	Reason for Leaving	FT/PT

Current Income/Month _____
Sources (Circle all that apply): Worker's Comp Social Security Disability Welfare Retirement
Other _____

DISABILITY:

No: ____ Yes: ____ What Type? _____
Temporary?____ Permanent? ____ With Whom? _____
% and $/month _____

MILITARY SERVICE:

Branch? _____
Where? _____
When? _____
Agent Orange Exposure? ____ Accidents/Illnesses? ____ Shell Shock? ____
Tropical Illness? _____ PTSD? _____ (details) _____
_____
Rank: _____ Type of Discharge: _____

LEGAL HISTORY:

Juvenile Problems (truancy, school suspensions, etc.) : Yes No

_____
_____
_____
_____

Misdemeanors (DUI, assaults, public intoxication, etc.) : Yes No

_____
_____
_____

Felonies (drug possession, fraud, etc.) : Yes No

_____
_____
_____

Current Litigation? (personal injury, liability, etc.) : Yes No
Type: Civil Criminal Worker's Comp Unknown
Details: _____
_____

FAMILY HISTORY:

Marital Status/Living Arrangement:

Single:	_____	Separated:	_____	Widowed	_____
Married:	_____	Divorced	_____	Same-Sex Partner	_____

Marital History (list marriages, length, children and reason for termination, i.e., divorce, widowed etc.) :

_____
_____
_____

Children (list children, ages, occupation and where they live – also any grandchildren) :

_____
_____
_____
_____

Parents/Stepparents (list names, ages, occupation and causes of death if deceased) :

_____
_____
_____
_____

Family Order:

	Younger	Older
Brothers:	_____	_____
Sisters:	_____	_____
Adopted:	_____	_____

MEDICAL HISTORY:

Hospitalizations (when, where, why, how long?) :

_____
_____
_____
_____

Traumas requiring medical attention (stitches, fractured bones, falls, automobile accidents, etc.) :

_____
_____
_____

HEAD TRAUMA:

Motor Vehicle Accidents (automobile, motorcycle, bicycle, ATV, other, or as a pedestrian) :
When _____
Loss of Consciousness _____ Area of Head Hit _____
Anterograde/Retrograde amnesia _____ Whiplash _____
Diagnosis _____ Treatment _____
Prescription _____
Hospitalizations _____
Aftereffects _____
Vision/Hearing/Memory/Weakness or problems _____

Dazed/Loss of Consciousness from any trauma to the head (e.g., sports, fights, falls, being hit) :
When _____
Loss of Consciousness _____ Physician _____
Ear Bleeding _____ Seizures _____
Diagnosis _____ Surgery _____
Prescription _____
Hospitalizations _____
Aftereffects _____
Vision/Hearing/Memory/Weakness or problems _____

Penetrating Head Injuries (entered the skull) :
When _____
Loss of Consciousness _____ Physician _____
Ear Bleeding _____ Seizures _____
Diagnosis _____ Surgery _____
Prescription _____
Hospitalizations _____
Aftereffects _____
Vision/Hearing/Memory/Weakness or problems _____

MEDICAL TESTS (specify dates, physician and findings, if known) :

_____ Angiogram (Heart or Head) _____
_____ Brain Scan (CT or MRI) _____
_____ EEG _____
_____ X-Rays (Head or Spine) _____
_____ Spinal Tap _____
_____ Ultrasound _____
_____ Neurological Office Exam _____
_____ PET _____
_____ SPECT _____
_____ Other _____

PSYCHIATRIC HISTORY: (If yes, please explain.)

Hospitalizations (dates, physician/counselor, why; was treatment helpful) :

_____
_____
_____
_____
_____

ECT/Chemical Shock Treatment (when, why, number of treatments, memory loss, etc.) :

_____
_____
_____
_____

Outpatient Therapy/Counseling (dates, physician/counselor, why; was treatment helpful) :

_____
_____
_____
_____
_____

Previous Psychological Testing (when, where, who, why, results) :

_____
_____
_____
_____
_____

Current Stressors (i.e., emotional, physical, financial, occupational, marital, familial, etc.) :

_____
_____
_____
_____
_____

Current Medications and Dosages (mg/day – why prescribed, how long, side effects) :

_____
_____
_____
_____
_____

Alcohol:

Current Use (Last 30 days): Yes No Past Use: Yes No
Length of Use: _____ How Much _____
Blackouts: Yes No Details _____
Alcoholic Seizures: Yes No Details _____
Police Encounters: Yes No Details _____

Drugs:

Current Use (Last 30 days): Yes No Past Use: Yes No

*If yes above, list drugs, length, how much, periods of heavy use, and date of last use:

Marijuana: _____
Cocaine/Crack: _____
Opiates: _____
Amphetamines: _____
Barbiturates: _____
Hallucinogens: _____
IV Use: _____
Other Drugs: _____

Family History of Substance Use/Abuse:

_____
_____

Prior In/Out Patient Substance or alcohol treatment (when, length, reason) :

_____
_____

Tobacco:

Current Use (Last 30 days): Yes No Past Use: Yes No
Length of Use: _____ How Much: _____
Type: _____ Problems: _____

CURRENT SENSORY/PHYSICAL SYMPTOMS:

Vision:
_____ Glasses/Contacts
_____ Blurred or Double Vision
_____ Loss of Vision/Blind Spots

Tactile: (specify where)
_____ Numbness/Loss of Sensation
_____ Tingling/Burning
_____ Pain/Temperature Sensitivity

Hearing:
_____ Hearing Aid (left, right, or both ears)
_____ Loss of Hearing
_____ Ringing
_____ Tone Deafness

Taste & Smell:
_____ Change in Taste
_____ Bad Tastes
_____ Change in Smell
_____ Bad Smells

Motor: (specify where)
_____ Decreased Coordination
_____ Weakness
_____ Paralysis
_____ Spasms/Tremors
_____ Chewing/Swallowing
_____ Range of Movement/Flexibility

Consciousness:
_____ Seizures or Fits
_____ Fainting or Blackout Spells
_____ Lapses of Time
_____ Dizziness While Sitting
_____ Dizziness Upon Standing

Pain: (specify where)
_____ None
_____ Headache (Constant OR Intermittent – tension, migraine, cluster, other)
_____ Back Pain (Constant OR Intermittent)
_____ Chest Pain (Constant OR Intermittent)
_____ Abdominal Pain (Constant OR Intermittent)
_____ Global Pain (Constant OR Intermittent)

COGNITIVE SYMPTOMS:

Attention:

_____ Distractibility
_____ Confusion/Orientation Deficits (forgetting day, date, or wherabouts)
_____ Concentration Deficits
(Must repeatedly read a book or newspaper before it makes sense. Cannot follow television show from start to finish)
_____ Path Finding Problems
(Patient gets lost driving to familiar places and/or has problems taking a bus)

Memory:

_____ Immediate Memory (names, faces, telephone numbers)
_____ Visual Memory Problems
_____ Verbal Memory Problems
_____ Memory Change (example) _____
_____ Short-term Recall - Difficulty remembering newly learned experience
_____ Long-term or Remote Recall - Difficulty remembering past experiences/events
_____ Absent-Mindedness
_____ Memory for Names/Faces
_____ Memory for Numbers
_____ Old Learning (e.g., balancing a checkbook, taking a bus, recipes, simple math or spelling)
_____ New Learning (able to learn something new involving 3 or 4 steps)

Speech:

_____ Difficulty Expressing Thoughts
_____ Difficulty Understanding Others
_____ Change in Articulation/Slurred or Mumbled Speech
_____ Trouble Finding Correct Word or Desired Word
_____ Saying Wrong or Inappropriate Word
_____ Word-naming Problems
_____ Hesitations
_____ Substitutions
_____ Speech Impediments
_____ Difficulty Constructing Sentences

Thought Processes:

_____ Trouble Organizing Thoughts
_____ Trouble Organizing Actions
_____ Slowed Thinking
_____ Decreased Problem Solving Ability
_____ Changes in Ability to Read
_____ Changes in Ability to Write
_____ Changes in Ability to Spell
_____ Changes in Ability to do Math

EMOTIONAL SYMPTOMS:

_____ Crying
_____ Sadness
_____ Hyperactivity
_____ Temper Outbursts
_____ Irritability/Argumentativeness
_____ Impulsiveness
_____ Change in Motivation
_____ Loss of Pleasure
_____ Anxiety/Tension/Nervousness
_____ Fears
_____ Social Withdrawal/Isolation
_____ Change in Alcohol or Tobacco Consumption
_____ Racing Thoughts
_____ Worry

SLEEPING PROBLEMS:

_____ Sleep Change (specify) _____
_____ Early/Middle/Late Onset Problems
_____ Number of Hours per Night
_____ Diurnal Variations (daily)
_____ Still Able to Function Despite Sleep Problems
_____ Stress-related Sleep Difficulties

APPETITE CHANGE:

_____ Weight Loss/Gain
_____ Number of Times
_____ Intentional
_____ Libido Changes _____
_____ Mood Swings _____
_____ Agitation/Panic Attacks _____
_____ Hallucinations _____
_____ Delusions _____
_____ Suicide Attempts/Gestures/Ideation _____
_____ Suicidal Thoughts/Ideation _____
_____ Current
_____ Past

Please indicate if these apply to yourself or specify a family member.

Self	Family Member	
_____	_____	Birth Problems/Trauma _____
_____	_____	Cerebral Palsy
_____	_____	Mental Retardation
_____	_____	Cystic Fibrosis
_____	_____	Polio Myelitis/Infantile Paralysis
_____	_____	Rheumatic Fever
_____	_____	Scarlet Fever
_____	_____	Learning Disability
_____	_____	Diabetes
_____	_____	High Blood Pressure (i.e., hypertension)
_____	_____	Heart Attacks (angina, myocardial infarction)
_____	_____	Strokes (CVA, TIA)
_____	_____	Encephalitis (Brain Infection)
_____	_____	Malaria
_____	_____	Pneumonia
_____	_____	Venereal Diseases
_____	_____	HIV/AIDS Status (when tested, results) _____
_____	_____	Tuberculosis (TB)
_____	_____	Other Infections (specify) _____
_____	_____	Cancer (specify location) _____
_____	_____	Heat Stroke
_____	_____	High Fever (over 104°)
_____	_____	Asthma/Respiratory Problems
_____	_____	Lung Diseases (specify) _____
_____	_____	Blood Diseases (specify) _____
_____	_____	Kidney/Liver Diseases (specify) _____
_____	_____	Ulcers/Other Gastrointestinal Problems
_____	_____	Tumor (cancerous or benign, specify location) _____
_____	_____	Seizures
_____	_____	Convulsions
_____	_____	Epilepsy
_____	_____	Tremors/Chorea
_____	_____	Chorea/St. Vitus Dance
_____	_____	Paralysis or Other Motor Problems (specify) _____
_____	_____	Exposure to/Overcome by Toxic Substances (e.g., gasses, chemicals, fumes)
_____	_____	Electric Shock (specify high voltage, lightning, high tension wires, electrical fixtures)
_____	_____	Period without Air (e.g., anoxia, hypoxia)
_____	_____	Loss of Consciousness (specify cause) _____
_____	_____	Fainting (i.e., syncope)
_____	_____	Head Injury
_____	_____	Concussion
_____	_____	Coma
_____	_____	Surgeries Requiring General Anesthesia
_____	_____	Alzheimer's Disease
_____	_____	Parkinson's Disease
_____	_____	Schizophrenia
_____	_____	Manic Depressive Illness (i.e., Bipolar Disorder)
_____	_____	Nervous Breakdowns
_____	_____	ECT
_____	_____	Substance Abuse (i.e., drug use)

____ _____ Alcoholism or Excessive Drinking
____ _____ Periods of Prolonged Use of Prescription Medications
____ _____ Headaches (specify type) _____
____ _____ Neck Pain
____ _____ Back Pain
____ _____ Arthritis
____ _____ Abuse (specify sexual, verbal, physical, emotional, maltreatment neglect, rape) _____
_____
____ _____ Other Medical Problems, Conditions or Diseases (please specify)
_____
_____
_____

ADDITIONAL INFORMATION YOU WOULD LIKE TO COMMUNICATE TO THE DOCTOR:

_____
_____
_____
_____
_____
_____
_____
_____
_____