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ADULT NEUROPSYCHOLOGICAL HISTORY

Name: ______________________________ Date: ____________________

Address (home): ______________________________ Phone: ______________

Email Address: ____

Age: ______ Date of Birth: ______________ Education: ____________________

College: ☐ Yes ☐ No If yes, where? When? Major? ____________________

Did you Graduate College: ☐ Yes ☐ No Highest Degree Completed: ____________________

Race: ______ Eyes: ________ Hair: __________ Height: ________ Weight: __________

Reason for Referral: ____

____

What is your objective for this evaluation: ________________________________

____

Occupation: ____

Hobbies and Interests: ____

Marital Status: __________ Spouse's/Significant Other's Name: ____________________

Children: ____

Father - Age: ______ Occupation: ____________________ Education: ______________

Mother - Age: ______ Occupation: ____________________ Education: ______________

Birth Order – Brothers: ____________________ Sisters: ____________________

MEDICAL/HEALTH HISTORY

Physician: ______________________________ Phone: ______________________

Address: ____

Date of last physical exam: ____

Vision problem? ☐ Yes ☐ No Date of last vision exam: ____________________________

Hearing problem? ☐ Yes ☐ No Date of last hearing exam: ___________________________

Appetite concerns? ☐ Normal ☐ Picky ☐ Eat too much ☐ Weight loss/gain

Oral-motor concerns? ☐ None ☐ Difficulty swallowing ☐ Drooling ☐ Gagging

Do you have problems falling asleep? ☐ Yes ☐ No If yes, how long does it take you? __________

Do you wake up in the middle of the night? ☐ Yes ☐ No If yes, how many times per night? _________

If yes, why? ______________________ How long does it take for you to go back to sleep? _____

Medication History:

Medication	Dosage	Frequency	Start date – End date	Reason for Discontinuing

Surgeries – (Age/Reason): ____

____

Hospitalizations – (Age/Reason): ____

____

Major accidents or injuries – (Age/Details): ____

____

____

Have you ever been unconscious? ☐ Yes ☐ No If yes, please explain: ____________________

____

Do you have current problems with:

	Yes	No	?		Yes	No	?
Ears (specify) **R L Both**				**Appetite, digestion, stomach problems**			
Poor hearing				Frequent stomach aches			
Chronic earaches/infections				Poor eating habits			
Draining ears				Frequent vomiting			
				Soiling or daytime accidents			
Eyes (specify) **R L Both**				Constipation			
Poor vision				Problems with weight			
Crossed eyes							
Wears glasses				**Hematology (Blood)**			
				Anemia			
Endocrine				Excessive bleeding or bruising			
Thyroid problems				Leukemia			
Diabetes				Sickle cell disease			
Hypo/Hyperpituitarism				Other:			
Growth problems							
Other:							
				Excretory System			
				Urine and/or bladder problems			
Nervous System				Bedwetting			
Frequent and/or severe headaches				Daytime wetting and/or accidents			
Seizures or convulsions				Urinary tract infections			
Tremors or twitches							
Coordination problems				**Respiratory System**			
Balance problems				Wheezing and/or asthma			
Frequent dizziness				Other:			
Other:							
Cancer				**HIV/AIDS**			

Have you had any of the following?

Ear Tubes	☐ Yes	☐ No	If yes, number of tube placements ______________
Encephalitis	☐ Yes	☐ No	
Meningitis	☐ Yes	☐ No	
Poisoning or drug intoxication	☐ Yes	☐ No	
Coma	☐ Yes	☐ No	If yes, what was the cause? ____________________
Staring spells	☐ Yes	☐ No	
Immune system disorders	☐ Yes	☐ No	
Other significant illness	☐ Yes	☐ No	

If yes to any of the above, please provide additional details: ____

____

Have you had any of the following tests or treatments?

	Yes	**No**	**Date (month/year)**	**Where**	**Results**
Neurologic Evaluation					☐ Normal ☐ Abnormal ☐ Don't know
CT Scan of head					☐ Normal ☐ Abnormal ☐ Don't know
MRI of head					☐ Normal ☐ Abnormal ☐ Don't know
EEG					☐ Normal ☐ Abnormal ☐ Don't know
Genetic Testing					☐ Normal ☐ Abnormal ☐ Don't know
Chemotherapy					☐ Normal ☐ Abnormal ☐ Don't know
Radiation Therapy					☐ Normal ☐ Abnormal ☐ Don't know
Other					☐ Normal ☐ Abnormal ☐ Don't know
					☐ Normal ☐ Abnormal ☐ Don't know

Have you ever had: ☐ Traumatic Brain Injury ☐ CVA/Stroke ☐Aneurysm ☐ Heart Attack

If yes, please provide the details for each:

Date: _____________ Loss of Consciousness: ☐ Yes ☐ No If yes, how long? _____________________________

Details: ____

____

____

____

____

DEVELOPMENT

Did your mother receive prenatal care during the pregnancy? ☐ Yes ☐ No Starting in which month? _________

Number of the following your mother has had (including you):
Pregnancies _______ Miscarriages _______ Premature Births _______

Did your mother have any of the following during or immediately before/after the pregnancy (check all that apply)

☐ Emotional stress
☐ Toxemia
☐ Excessive swelling (edema)
☐ Flu
☐ Vaginal bleeding-when?_______
☐ Epilepsy/seizure
☐ Other (Rh incompatibility, etc.)
☐ Infections (cold, flu)
☐ Anemia
☐ Measles/German measles
☐ High blood pressure
☐ Strep throat
☐ X-ray studies
☐ Diabetes
☐ Preterm labor/bedrest
☐ Abnormal weight gain
☐ Excessive vomiting
☐ Kidney disease
☐ Threatened miscarriage
☐ Fever
☐ Other virus
☐ Maternal injury. Describe: ____
☐ Operation/hospitalization during pregnancy. Reason: ____

Were any of the following used during your Mother's pregnancy with you? (check all that apply)

☐ Prescribed medications. (Please specify): ______________________ For: ______________________________
☐ Tobacco
☐ Amphetamines
☐ Cocaine
☐ Marijuana
☐ Heroin
☐ Alcohol
☐ Methamphetamines
☐ Methadone
☐ Other (specify) _______________________

BIRTH HISTORY

Age of mother at birth? ________ Age of father at birth? ________

Were you born full term? ☐ Yes ☐ No Number weeks gestation _______

Birth weight: _____lbs. _____oz. APGARS (if remembered) _____ at 1 min _____ at 5 min.

Type of Labor Onset: ☐ Induced ☐ Spontaneous

Type of Birth: ☐ Vaginal ☐C/Section (Planned? ☐ Yes ☐ No Emergency? ☐ Yes ☐No)
☐ Vaginal Birth after C/Section (VBAC) ☐ With Instruments (forceps)

Type of Anesthesia: ☐ Gas ☐ Spinal ☐ Local ☐ None

Baby's Presentation: ☐ Breech ☐ Head ☐ Transverse (sideways)

Please check the following problems that may have occurred during labor:

Yes	No		Yes	No	
☐	☐	Toxemia/eclampsia	☐	☐	Fetal distress
☐	☐	Maternal fever	☐	☐	Medications used (please specify):

Length of active labor: _______hours. Describe any complications during delivery: ________________________

____

POST-DELIVERY PERIOD

Check which of the following problems may have occurred after your birth, if known:

Yes	No		Yes	No	
☐	☐	Trouble breathing	☐	☐	Jaundice
☐	☐	Cord around the neck (# of times ____)	☐	☐	Poor feeding
☐	☐	Knot in cord	☐	☐	Were you nursed? How long? _________
☐	☐	Seizures	☐	☐	Required a blood transfusion
☐	☐	Hemorrhage (bleeding) in head	☐	☐	Vomiting / reflux
☐	☐	Hydrocephalus (water on the brain)	☐	☐	Floppy muscle tone
☐	☐	Cyanosis (turned blue)	☐	☐	Infection
☐	☐	Need for ventilation	☐	☐	Fever
☐	☐	Incubator care	☐	☐	Other ______________________________

Have you been given a specific diagnosis?

☐ Learning Disability
☐ Language disorder
☐ Attention Deficit Disorder (ADHD)
☐ Oppositional Defiant Disorder (ODD)
☐ Autism/ Asperger's/ PDD
☐ Other
☐ Intellectual Disability
☐ Developmental Delay
☐ Epilepsy
☐ Tourette's Disorder
☐ Fragile X
☐ Genetic Disorder
☐ Anxiety Disorder
☐ Depression
☐ Bipolar Disorder
☐ Schizophrenia

LANGUAGE

First Language: ____

History of Speaking/Language Difficulties: ☐ Yes ☐ No If yes, please explain: ____________________

____

MILITARY SERVICE

Branch of Military and Dates of Service: ____________________________________

Highest Rank: ____

Jobs Held: ____

Combat History: ____

Conduct Problems: ☐ Yes ☐ No If yes, please explain: ____________________________

Rank at Discharge: ____

Type of Discharge: ____

FAMILY MEDICAL HISTORY

Have any of your family members had the following problems/disorders? Please specify the family member's relationship to you 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		Family Member(s) Relation
☐ Birth Defect	________	☐ Reading Problem(s)	________
☐ Genetic Disorder	________	☐ Other Learning Disability	________
☐ Cerebral Palsy	________	☐ Speech/Language Delay	________
☐ Migraines	________	☐ Intellectual Disability	________
☐ Multiple Sclerosis	________	☐ Autism/Asperger's	________
☐ Physical Handicap	________	☐ ADHD	________
☐ Huntington's Chorea	________	☐ Oppositional Behaviors	________
☐ Muscular Dystrophy	________	☐ Antisocial Behavior	________
☐ Sickle Cell Anemia	________	☐ Aggression	________
☐ Seizures/Epilepsy	________	☐ Tics/Tourette's Disorder	________
☐ Cancer	________	☐ Anxiety/Nervousness	________
☐ Diabetes	________	☐ Obsessive-Compulsive	________
☐ Heart Disease	________	☐ Depression	________
☐ Alcohol Abuse	________	☐ Bipolar Disorder	________
☐ Drug Abuse	________	☐ Schizophrenia	________
☐ Physical Abuse	________	☐ Other (specify)	________
☐ Sexual Abuse	________	☐	________

FAMILY

Father

Name: ______________________ Birthday/Current age: __________ Education: __________

Occupation: ____

Marital History: ______________________ Personality: ______________________

Relationship with patient: ____

Health status/problems: ____

Psychiatric History: ____

Substance Abuse: ____

Legal Difficulties: ____

Mother

Name: ______________________ Birthday/Current age: __________ Education: __________

Occupation: ____

Marital History: ______________________ Personality: ______________________

Relationship with patient: ____

Health status/problems: ____

Psychiatric History: ____

Substance Abuse: ____

Legal Difficulties: ____

Sibling

Name: ______________________ Birthday/Current age: __________ Education: __________

Occupation: ____

Marital History: ______________________ Personality: ______________________

Relationship with patient: ____

Health status/problems: ____

Psychiatric History: ____

Substance Abuse: ____

Legal Difficulties: ____

Sibling

Name: ______________________________ Birthday/Current age: __________ Education: __________

Occupation: ____

Marital History: __________________________ Personality: ______________________________

Relationship with patient: ____

Health status/problems: ____

Psychiatric History: ____

Substance Abuse: ____

Legal Difficulties: ____

Sibling

Name: ______________________________ Birthday/Current age: __________ Education: __________

Occupation: ____

Marital History: __________________________ Personality: ______________________________

Relationship with patient: ____

Health status/problems: ____

Psychiatric History: ____

Substance Abuse: ____

Legal Difficulties: ____

Sibling

Name: ______________________________ Birthday/Current age: __________ Education: __________

Occupation: ____

Marital History: __________________________ Personality: ______________________________

Relationship with patient: ____

Health status/problems: ____

Psychiatric History: ____

Substance Abuse: ____

Legal Difficulties: ____

SEXUAL

Puberty (what age?): _______ Changes in sexual behavior?: ☐ Yes ☐No If yes, please explain: __________

____Sexual Problems: ☐ Yes ☐ No

If yes, please explain: ____

MARITAL

Marital Status: ____________________ Name/Age of Spouse/Significant Other: _________________________

Occupation of Spouse: ____

Marital Problems: ☐ Yes ☐ No If yes, please explain: ____

Previous Marriage(s): ____

SOCIAL/RECREATIONAL

Social Contact Level: ____

Social Activities: ____

Hobbies: ____

Amount of Social/Leisure Time/Week: ____

LEGAL

Problems as a juvenile: ☐ Yes ☐ No If yes, please explain: ____

____

Misdemeanor Offenses: ☐ Yes ☐ No If yes, please explain: ____

____

Felony Arrests/Offenses: ☐ Yes ☐No If yes, please explain: ____

____

Convictions: ☐ Yes ☐No If yes, please explain: ____

____

Time served: ☐ Yes ☐No If yes, please explain: ____

____

Lawsuits/Civil Litigation ☐ Yes ☐No If yes, please explain: ____

____

SYMPTOM SURVEY

Below is a list of items and behaviors that commonly describe people. Please check all behaviors that you currently exhibit or have exhibited in the past. Please add any helpful comments next to the items.

PROBLEM SOLVING

Current	Past	
☐	☐	Difficulty figuring out how to do new things
☐	☐	Difficulty making decisions
☐	☐	Difficulty planning ahead
☐	☐	Difficulty solving problems
☐	☐	Disorganized in your approach to problems
☐	☐	Difficulty understanding explanations
☐	☐	Difficulty doing things in the right order (sequencing)
☐	☐	Difficulty verbally describing the steps involved in doing something
☐	☐	Difficulty completing an activity in a reasonable period of time
☐	☐	Difficulty changing a plan or activity when necessary
☐	☐	Is slow to learn new things
☐	☐	Difficulty switching from one activity to another activity
☐	☐	Easily frustrated
☐	☐	Other problem solving difficulties:

SPEECH, LANGUAGE, AND MATH SKILLS

Current	Past	
☐	☐	Difficulty speaking clearly
☐	☐	Difficulty finding the right word to say
☐	☐	Not talking
☐	☐	Rambles on and on without saying much
☐	☐	Jumps from topic to topic
☐	☐	Odd or unusual language or vocal sounds
☐	☐	Difficulty understanding what others are saying
☐	☐	Difficulty understanding what you are reading
☐	☐	Difficulty writing letters or words
☐	☐	Difficulty reading letters or words
☐	☐	Difficulty with math
☐	☐	Other speech, language, or math problems:

SPATIAL SKILLS

Current	Past	
☐	☐	Confusion telling right from left
☐	☐	Has difficulty with puzzles, or assembling items from diagrams
☐	☐	Problems drawing or copying
☐	☐	Don't know your colors
☐	☐	Difficulty dressing (not due to physical difficulty)
☐	☐	Problems finding your way around places you have been to before
☐	☐	Difficulty recognizing objects
☐	☐	Seem unable to recognize facial or body expressions of disapproval or emotions
☐	☐	Gets lost easily
☐	☐	Other spatial problems:

AWARENESS AND CONCENTRATION

Current	Past	
☐	☐	Easily distracted by: Sounds ☐ Sights ☐ Physical sensations ☐
☐	☐	Mind appears to go blank at times
☐	☐	Loses train of thought
☐	☐	Difficulty concentrating on what others say, but can sit in front of a TV for long periods
☐	☐	Attention starts out OK but can't keep it up
☐	☐	Other attention or concentration problems:

MEMORY

Current	Past	
☐	☐	Forget where you leave things
☐	☐	Forget things that happened recently (e.g., last meal)
☐	☐	Forget things that happened days/weeks ago
☐	☐	Forget what you are supposed to be doing
☐	☐	Forget names more than most people do
☐	☐	Forget work assignments
☐	☐	Forget instructions
☐	☐	Other memory problems:
☐	☐	
☐	☐	

PHYSICAL

Current	Past	
☐	☐	Frequently complain of headaches or nausea How often?
☐	☐	Have dizzy spells How often?
☐	☐	Have pains in joints Where?
☐	☐	Excessive tiredness When?
☐	☐	Frequent urination or drinking
☐	☐	Other physical problems:

MOTOR AND COORDINATION

Current	Past	
☐	☐	Fine motor control problems (using a pen/pencil) **R side L side Both**
☐	☐	Clumsy **R side L side Both**
☐	☐	Weakness **R side L side Both**
☐	☐	Tremor **R side L side Both**
☐	☐	Muscles are tight or spastic **R side L side Both**
☐	☐	Odd movements (posturing, peculiar hand movements, etc.) **R side L side Both**
☐	☐	Drop things more than most people **R side L side Both**
☐	☐	Have an unusual walk
☐	☐	Balance problems
☐	☐	Other motor or coordination problems:

SENSORY

Current	Past	
☐	☐	Needs to squint or move closer to page to read **R side L side Both**
☐	☐	Problems seeing objects **R side L side Both**
☐	☐	Loss of feeling **R side L side Both**
☐	☐	Problems hearing sounds **R side L side Both**
☐	☐	Difficulty telling hot from cold **R side L side Both**
☐	☐	Difficulty smelling odors **R side L side Both**
☐	☐	Difficulty tasting food **R side L side Both**
☐	☐	Overly sensitive to: ☐Touch ☐ Light ☐ Noise
☐	☐	Other sensory problems:
☐	☐	

BEHAVIOR

Current	Past		Current	Past	
☐	☐	Aggressive	☐	☐	Nervous
☐	☐	Attached to things, not people	☐	☐	Nightmares, night terrors, sleepwalks
☐	☐	Toileting Accidents (day / night)	☐	☐	Quiet
☐	☐	Unusual behavior	☐	☐	Resists change
☐	☐	Bowel movements in underwear	☐	☐	Risk-taking
☐	☐	Dependent	☐	☐	Self-mutilates
☐	☐	Depressed	☐	☐	Self-stimulates
☐	☐	Eating habits are poor	☐	☐	Shy and withdrawn
☐	☐	Emotional	☐	☐	Sleeping habits are poor
☐	☐	Fearful	☐	☐	Swears a lot
☐	☐	Immature	☐	☐	Unmotivated

Do you currently (within the past 6 months) display any of the following behaviors frequently?

These behaviors should occur more frequently than in others the same age

- ☐ Fainting, falling
- ☐ Clumsiness
- ☐ Shy, timid
- ☐ Social Isolation
- ☐ Lack of confidence
- ☐ Low self-esteem
- ☐ Crying episodes
- ☐ Unhappiness
- ☐ Concern with weight
- ☐ Sleep problem
- ☐ Anxiety
- ☐ Unusual fears
- ☐ Avoidance
- ☐ Laziness
- ☐ Other:
- ☐ Poor concentration
- ☐ Short attention span
- ☐ Distractibility
- ☐ Low frustration tolerance
- ☐ Impulsivity
- ☐ Hyperactivity
- ☐ Attention seeking
- ☐ Irritability
- ☐ Temper tantrums
- ☐ Oppositional behavior
- ☐ Noncompliance
- ☐ Defiance
- ☐ Lying
- ☐ Obsessive-compulsive behaviors
- ☐ Stereotyped/repetitive behaviors
- ☐ Memory loss
- ☐ Physical aggression
- ☐ Stealing
- ☐ Use of profanity
- ☐ Skipping work
- ☐ Fire setting
- ☐ Destructiveness
- ☐ Cruelty to animals
- ☐ Gang Involvement
- ☐ Cigarette use
- ☐ Alcohol / Substance use

Overall your symptoms have developed: ☐ Slowly ☐ Quickly

The symptoms occur: ☐ Occasionally ☐ Often

Over the past six (6) months, the symptoms have: ☐ stayed about the same ☐ worsened

SERVICES/INTERVENTIONS PREVIOUSLY SOUGHT

- ☐ Medical Evaluation
- ☐ Neuropsychological Evaluation
- ☐ Occupational Evaluation/Treatment
- ☐ Other:
- ☐ Neurological Exam/Evaluation
- ☐ Speech/Language Evaluation/Therapy
- ☐ Physical Therapy Evaluation/Treatment
- ☐ Psychiatric Exam/Evaluation
- ☐ Psychological Evaluation/Treatment
- ☐ Medication

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

Individual psychotherapy	☐ Yes	☐ No	Duration of therapy?
Group psychotherapy	☐ Yes	☐ No	Duration of therapy?
Parenting classes	☐ Yes	☐ No	Duration of classes?
Residential treatment	☐ Yes	☐ No	Duration of placement?

PSYCHIATRIC HISTORY

Emotional/Psychological problems: ______________________________

____

Psychiatric diagnoses (type/age): ______________________________

____

Treatment history (type/age): ______________________________

____

Medications: ______________________________

____

Therapies: ______________________________

____

Hospitalizations: ______________________________

____

Suicidal Ideations/Gestures: ______________________________

____

ADDITIONAL INFORMATION

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