Neuropsychology Consultants

Patient Information Form - Neuropsychological

Date: ___________________

Name: ___________________________ Age: _____ Gender: ____ Birth Date: _________

Referred by: ___________________________ Primary Care Physician: _________________

Reason for your referral: ________________________

MEDICAL HISTORY

Please list any medical conditions you currently have or have had in the past:

	Illness or Serious Injury	Currently	If no, when in the past
1.		YES NO	
2.		YES NO	
3.		YES NO	
4.		YES NO	
5.		YES NO	
6.		YES NO	
7.		YES NO	
8.		YES NO	

Current Medications	Dosage	Times per day	Date started	Prescribing Provider

Have you ever had a negative response to any medication? ___________________________

If yes, what was the medication and what was your reaction?

___

Please list any previous hospitalizations/operations:

	Condition	Date	Hospital
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Have you ever had?

an MRI scan of the brain?	YES NO	**If yes, when?**
a CAT scan of the brain?	YES NO	**If yes, when?**
an EEG?	YES NO	**If yes, when?**
a Carotid Doppler test?	YES NO	**If yes, when?**
a Sleep Study?	YES NO	**If yes, when?**
a Neuropsychological Evaluation?	YES NO	**If yes, when?** **By Whom?**

Have you ever had?

Vision Problems?	NO YES	**Glasses:**	NO YES	
		Glaucoma:	NO YES	Right eye Left eye
		Blurring:	NO YES	Right eye Left eye
		Double vision:	NO YES	
		Other:		
Hearing Problems?	NO YES	**Hearing aids:**	NO YES	Right ear Left ear
		Ringing:	NO YES	Right ear Left ear
		Buzzing:	NO YES	Right ear Left ear
		Other:		
Stroke?	NO YES			
Head injury?	NO YES			

Question	Answer	Details
Episodes where you passed out, blacked out, or fainted (lost consciousness)?	NO YES	Describe:
Other neurological problems?	NO YES	
High Blood Pressure?	NO YES	
High Cholesterol?	NO YES	
Diabetes?	NO YES	Describe:
Seizures?	NO YES	**What type:** Grand Mal Petite Mal Absence **How often:**__________
Headaches?	NO YES	**What type:** Tension Migraine Sinus **How often:**__________
Tremors?	NO YES	Describe:
Balance problems?	NO YES	Describe:
Urinary Incontinence?	NO YES	Describe:
Weakness in any part of your body?	NO YES	Describe:
Numbness in any part of your body?	NO YES	Describe:
Any motor vehicle accidents?	NO YES	**How many accidents?**_____________ **Were you seriously injured?** NO YES **Were you hit on the head?** NO YES **Were you knocked out?** NO YES **For how long?**_______ minutes hours days
Are you involved in any lawsuits?	NO YES	
Have you ever been convicted of a crime?	NO YES	

Have you recently had:

Question	Answer
Brief episodes that included:	
Changes in your vision	NO YES
Tingling in part of your body	NO YES
Weakness in parts of your body	NO YES

Question	Response	Details
Changes in the ability to use your hands?	NO YES	**Due to:** / **Hand:** **Weakness:** NO YES RIGHT LEFT **Tremors:** NO YES RIGHT LEFT **Arthritis:** NO YES RIGHT LEFT **Poor Coordination:** NO YES RIGHT LEFT **Other:**
Problems with your sense of direction?	NO YES	MILD MODERATE SEVERE
Problems with your sense taste?	NO YES	MILD MODERATE SEVERE
Problems with sense of smell?	NO YES	MILD MODERATE SEVERE
Problems with nausea?	NO YES	MILD MODERATE SEVERE
Had recent changes in weight or appetite?	NO YES	**Appetite change:** MILD MODERATE SEVERE **Weight change:** _________Pounds Loss or Gain
Felt depressed recently?	NO YES	MILD MODERATE SEVERE
Experienced anxiety recently?	NO YES	MILD MODERATE SEVERE
Past mental health diagnoses and/or treatment?	NO YES	
Heard or seen things that others have not?	NO YES	
Are you currently thinking about suicide?	NO YES	
Have you ever thought about or attempted suicide?	NO YES	
Have there been changes in the way you get along with your family members?	NO YES	MILD MODERATE SEVERE **Please describe:**
Has anyone noticed changes in your personality?	NO YES	MILD MODERATE SEVERE **Please describe:**
Have you had less interest in social activities or time with friends?	NO YES	MILD MODERATE SEVERE
Have you felt more irritable?	NO YES	MILD MODERATE SEVERE

Please indicate any **family** history of:

Condition		**Family member**
Strokes	YES NO	
Seizures	YES NO	
Alzheimer's disease or other type of dementia	YES NO	
High Blood Pressure	YES NO	
Heart Disease	YES NO	
Depression	YES NO	
Anxiety	YES NO	
Other Mental Health problems	YES NO	
Other serious medical conditions		
Do you smoke cigarettes currently?	NO YES	______ **Packs per day**
Have you smoked cigarettes in the past?	NO YES	______ **Packs per day,** for _______ years **Year stopped:** ______
Do you drink alcohol currently?	NO YES	______ **Drinks per week** (1 drink = 1 beer, or 1 glass of wine, or 1 mixed drink)
Have you used alcohol in the past?	NO YES	______ **Drinks per day,** for ______ years **Year stopped:** ______ **Type of Alcohol:** ______________________________
Do you use recreational drugs currently?	NO YES	**Describe:**
Have you used recreational drugs in the past?	NO YES	
Have you ever overused prescription medication to relieve pain or distress?	NO YES	

Do You:

Have problems with memory?	NO YES	MILD MODERATE SEVERE **Memory loss:** **Worsened gradually** YES NO **Began suddenly** YES NO **Occurs off & on** YES NO **Is worse at end of the day** YES NO
Have problems understanding what you read?	NO YES	MILD MODERATE SEVERE
Have problems understanding what other people say?	NO YES	MILD MODERATE SEVERE **Is this because of poor hearing?** NO YES SOME
Have changes in your handwriting?	NO YES	MILD MODERATE SEVERE
Have problems concentrating or paying attention?	NO YES	MILD MODERATE SEVERE
Have problems finding the "right" word when talking?	NO YES	MILD MODERATE SEVERE
Have problems remembering names?	NO YES	MILD MODERATE SEVERE
Have problems with math?	NO YES	MILD MODERATE SEVERE
Have problems with handling money?	NO YES	MILD MODERATE SEVERE
Have problems managing your finances?	NO YES	MILD MODERATE SEVERE

Do you need assistance with any of the following activities?

Activity	Never	Sometimes	Always
Cleaning house			
Preparing meals			
Paying bills			
Keeping track of medication			
Transportation (Driving)			
Bathing			
Dressing			
Walking			
Getting up and down			

SOCIAL INFORMATION

Marital Status: Single

Divorced Widowed How long have you lived alone?__________

Married Co-habitating How long have you lived together?________

How is the health of your partner? GOOD FAIR POOR

# of marriages_____ Please list partner's health problems________

____

City of Residence	Names of People living with you	Relationship to you

Names of children not living with you	Relationship	Place of residence

DEVELOPMENTAL HISTORY

Are you aware of any of the following?: (check all that apply)

____ Problems during prenatal development?

____ Exposure to drugs or alcohol prenatally?

Developmental delay in: ____Speech/language

____Motor Skills

____Physical Development

____Social Development

____ Serious childhood illness or injury?

Handedness: ☐ Right ☐ Left As a child, were you forced to change hands? YES NO

SCHOOL INFORMATION

Last school grade completed?_________ **Degrees Received**_______________________________

How would you describe your grades? EXCELLENT ABOVE AVERAGE AVERAGE POOR FAILING

UNDERACHIEVER OTHER:________________________

If you left school before graduation, what was the reason?_______________________________

List any special training or education:____

Did you have any learning problems in school? YES NO

If yes, circle which were problem areas: READING WRITING MATH BEHAVIORAL

PAYING ATTENTION OTHER:_______________

Were you diagnosed with learning disabilities, ADHD, or other problems? YES NO

If yes, did you receive any special help? YES NO

WORK HISTORY

Primary Occupation:____

Are you retired? NO YES If yes, since when:_________________________________

Type of retirement: VOLUNTARY MEDICAL

Current activities: ____

Are you disabled? NO YES If yes, since when:_________________________________

What caused the disability?_________________________

Do you receive Social Security benefits? YES NO

Do you receive Private Disability benefits? YES NO

Please list your last several jobs:

Position	Employer	Approximate dates of employment

Did you serve in the military? : YES NO

What branch? ___________________________

Primary job responsibilities?_____________________________________

How long? : Active: _______________ Reserves: ___________________

Were you exposed to combat situations? : YES NO

PSYCHOSOCIAL HISTORY

<table>
<tr><td>How would you describe your childhood?</td><td colspan="2">Circle all that apply:
HAPPY NORMAL DIFFICULT TROUBLED LONELY
IDYLLIC CALM SAD FEARFUL DEPRIVED
OTHER (PLEASE DESCRIBE):</td></tr>
<tr><td>Have you ever experienced any traumatic events in your life?</td><td>NO YES</td><td>If yes, circle all that apply:
DEATH OF PARENT OTHER DEATHS
VERBAL ABUSE PHYSICAL ABUSE
SEXUAL ABUSE FAMILY VIOLENCE
CRIME VICTIM NEGLECT
OTHER (PLEASE DESCRIBE):</td></tr>
<tr><td colspan="3">List any other significant events in your childhood or later life:</td></tr>
<tr><td colspan="3">Are there any other areas of concern?</td></tr>
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