

ADULT NEUROPSYCHOLOGICAL HISTORY

Name: _____ Date: _____
Person completing form (if other than client): _____ Relationship to client: _____
Source of referral: _____

PERSONAL INFORMATION

Birthdate: ____/____/____
Address: _____
Phone: _____ E-mail: _____
Religious Preference: _____ Ethnic Group/Race: _____
Handedness (i.e., Right, Left, Ambidextrous): _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____ Phone: _____

GENERAL DEVELOPMENT HISTORY:

Describe any unusual illness, conditions, or accidents during your mother's pregnancy/delivery of you (e.g., German measles, Rh incompatibility, false labor, toxemia, breech birth, Caesarian section, etc.) _____

Did either parent use drugs or alcohol before or during the pregnancy? If so, please explain.

Length of Pregnancy: _____ Duration of Labor: _____ Birth Weight: _____

Were there any complications following your birth (e.g., jaundice, trouble breathing, early illnesses)? _____

Were there any delays in meeting your developmental milestones (e.g., crawling, walking, speaking, toilet training)? _____

MEDICAL HISTORY

Medical conditions:

Date Diagnosed

Is condition controlled?

1. _____
 2. _____
 3. _____
 4. _____
- Others: _____

Do you have seizures? _____ If yes, indicate date of onset, type of seizure, frequency, and date of last seizure _____

Have you ever had a head injury? _____ If yes, indicate date and describe: _____

Have you ever had a stroke? _____ If yes, indicate date and symptoms: _____

Describe any other accidents or surgical procedures you have had: _____

Do you have a family physician? _____ Name and Address: _____

Date/Result of most recent physical: _____

Eyes Examined ? ____ Yes ____ No Results? _____ Ears Examined? ____ Y ____ No Results? _____

Have you had a recent neurological examination? _____ Where? _____ Who? _____
Reason for exam: _____

List current Medications:

Name:	Dose	Taken for what condition	Taken for how long
1.			
2.			
3.			
4.			
5.			
6.			
7.			
Others: _____			

Are you allergic to any medications? _____. If yes, please list medications and reactions: _____

Family medical history (state name of relative and condition): _____

Describe your current alcohol use (type, how much, how often) _____

Describe current street drug use: _____

Do you have a history of alcohol or drug abuse? _____ If yes, describe _____

Have you been in treatment for substance abuse? _____ Is yes, describe _____

Have you ever been physically abused?	Yes	No
been sexually abused?	Yes	No
been neglected?	Yes	No

If yes, please explain _____

PSYCHIATRIC HISTORY:

Have you had a recent psych/behavioral/neuropsych examination? _____ Location/Name of Examiner _____

Reason for

evaluation: _____

Have you ever received psychiatric care (therapy or hospitalization)? _____

Where? _____

Treatment

Type/Dates: _____

Reason for

Treatment: _____

Do you currently see a psychiatrist or psychologist? _____ Who? _____ For how long? _____

Has any one in your family received psychiatric care (therapy or hospitalization)? _____

Who? _____

Treatment

Type: _____

Reason for

Treatment: _____

EDUCATIONAL HISTORY:

Highest level of education completed _____ Schools attended _____

Were you a/an: ____A/B student ____B/C student ____C/D student ____D/F student ____

Did you repeat any grades? _____ If

yes, why? _____

Describe any learning problems you had in school: _____

Does any family member have a learning problem (describe)? : _____

OCCUPATIONAL HISTORY:

Current occupation:_____ How long in current position?_____

List prior positions and length of time in each_____

Any problems with your current job performance?_____ If yes, describe_____

Have you ever been fired/let go from a job?_____ If yes, describe when and why_____

SOCIAL HISTORY:

Marital Status:_____ If Separated/Divorced/Widowed, how long?_____

If married, how long?_____ How many times married?_____

Current spouses'/partners' name, occupation, and health status_____

Children:

Name:	Location	Birthdate	Education	Health Status
1.				
2.				
3.				
4.				
5.				

Name/relationship of people living with you:_____

Do you live alone?_____ What type of setting do you live in (apartment, house, assisted living, etc)?_____

Do you have a legal guardian/durable power of attorney?_____

Do you manage your own medications?_____ If no, why not?_____

Do you handle your own finances?_____ If no, why not?_____

Do you drive?_____ If no, when stopped and why?_____

Recent accidents/problems with driving_____

CURRENT COMPLAINTS

Please check all conditions that apply to you at the present time:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Exuberant/joyous | <input type="checkbox"/> Angry/resentful | <input type="checkbox"/> Changes in vision |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Unable to listen | <input type="checkbox"/> Spiteful/vindictive | <input type="checkbox"/> Changes in motor functioning |
| <input type="checkbox"/> Decreased interest in fun activities | <input type="checkbox"/> Misplacing objects | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Changes in smell/taste |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Fears/worries | <input type="checkbox"/> Changes in hearing |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Sleeping less | <input type="checkbox"/> Buying sprees | <input type="checkbox"/> Jumpy | _____ |
| <input type="checkbox"/> Sleeping more | <input type="checkbox"/> Increased sexual activity | <input type="checkbox"/> Repeated thoughts of painful event | _____ |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Increased risk taking behavior | <input type="checkbox"/> Difficulty following instructions | _____ |
| <input type="checkbox"/> Fatigue/loss of energy | <input type="checkbox"/> Unusual beliefs/thoughts | <input type="checkbox"/> Repetitive/unusual behavior | |
| <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Forgetfulness | |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Fidgety/squirmy | <input type="checkbox"/> Changes in speech/language | |
| <input type="checkbox"/> Thoughts of death | <input type="checkbox"/> Difficulty waiting | <input type="checkbox"/> Forgetting names | |
| <input type="checkbox"/> Suicidal ideation | <input type="checkbox"/> Interrupting/blurting out | <input type="checkbox"/> Getting lost | |
| <input type="checkbox"/> Losing temper | <input type="checkbox"/> Change in use of alcohol or drugs | <input type="checkbox"/> Not recognizing people you know | |
| <input type="checkbox"/> More talkative | <input type="checkbox"/> Difficulty finishing tasks | <input type="checkbox"/> Difficulty making decisions | |
| <input type="checkbox"/> Giddy/boisterous | <input type="checkbox"/> Often shifting activities | <input type="checkbox"/> Personality changes | |