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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:

- ___Depressed
- ___Irritable
- ___Decreased interest in fun activities
- ___Weight loss
- ___Weight gain
- ___Sleeping less
- ___Sleeping more
- ___Restlessness
- ___Fatigue/loss of energy
- ___Feelings of worthlessness
- ___Difficulty concentrating
- ___Thoughts of death
- ___Suicidal ideation
- ___Losing temper
- ___More talkative
- ___Giddy/boisterous
- ___Exuberant/joyous
- ___Unable to listen
- ___Misplacing objects
- ___Racing thoughts
- ___Easily distracted
- ___Buying sprees
- ___Increased sexual activity
- ___Increased risk taking behavior
- ___Unusual beliefs/thoughts
- ___Hallucinations
- ___Fidgety/squirmy
- ___Difficulty waiting
- ___Interrupting/blurting out
- ___Change in use of alcohol or drugs
- ___Difficulty finishing tasks
- ___Often shifting activities
- ___Angry/resentful
- ___Spiteful/vindictive
- ___Flashbacks
- ___Fears/worries
- ___Nightmares
- ___Jumpy
- ___Repeated thoughts of painful event
- ___Difficulty following instructions
- ___Repetitive/unusual behavior
- ___Forgetfulness
- ___Changes in speech/language
- ___Forgetting names
- ___Getting lost
- ___Not recognizing people you know
- ___Difficulty making decisions
- ___Personality changes
- ___Changes in vision
- ___Changes in motor functioning
- ___Changes in smell/taste
- ___Changes in hearing
- ___Other_____
  _____
  _____
  _____