

# Neuropsychology History Form

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## Adult Patient Information Questionnaire

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### General Information

Patient's Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Person Completing this Form: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Who referred you to our service? Please provide contact information: \_\_\_\_\_

Is this referral a result of or related to any legal or court proceedings? If so please provide name of attorney. \_\_\_\_\_

What is the primary language spoken at home? \_\_\_\_\_

What was the first language learned? \_\_\_\_\_

Is the patient right-handed, left-handed, or ambidextrous? \_\_\_\_\_

Please list the reasons for your visit:

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What are your goals for the evaluation?:

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### **General Medical History**

Name and phone number of primary care physician: \_\_\_\_\_

Name and phone number of specialist: \_\_\_\_\_

Have you had any neuroimaging (e.g., EEG/MRI/fMRI/CT)? **Yes No** If yes, please bring reports if available.

Do you drive currently? **Yes No** If yes, have there been any incidents in the past two years (e.g., confusion/lost/ticket/accident)? Please explain: \_\_\_\_\_  
\_\_\_\_\_

Describe your use of alcohol/tobacco/recreational drugs: \_\_\_\_\_  
\_\_\_\_\_

**Symptom Survey**

Please place a mark (✓) next to each symptom that applies, and note date of onset if possible:

<b>Physical concerns</b>	<b>Date of Onset</b>
Headaches	_____
Dizziness	_____
Balance problems	_____
Urinary problems	_____
Bowel problems	_____
Strength problems	_____
Motor problems	_____
Other physical concerns? _____	

<b>Sensory concerns</b>	<b>Date of Onset</b>
Numbness	_____
Tingling	_____
Visual impairment	_____
Wear glasses?   Yes   No	_____
See things that are not there	_____
Hearing impairment	_____
Wear hearing aid?   Yes   No	_____
Problems with taste or smell?	_____
Other sensory concerns? _____	

<b>Intellectual concerns</b>	<b>Date of Onset</b>
<i>Problem Solving</i>	
Difficulty figuring out how to do new things	_____
Difficulty figuring out problems that most others can do	_____
Difficulty planning ahead	_____
Difficulty changing a plan or activity when necessary	_____
Difficulty thinking as quickly as needed	_____
Difficulty doing things in the right order (sequencing)	_____

<b>Language and Math Skills</b>	<b>Date of Onset</b>
Difficulty finding the right word	_____

Slurred speech \_\_\_\_\_  
 Difficulty expressing thoughts \_\_\_\_\_  
 Difficulty understanding what others say \_\_\_\_\_  
 Difficulty understanding what I read \_\_\_\_\_  
 Difficulty writing letter or words (not due to a motor problem) \_\_\_\_\_  
 Difficulty with math (e.g., balancing checkbook, making change) \_\_\_\_\_  
 Other language or math problems? \_\_\_\_\_

*Nonverbal skills*

Difficulty telling right from left \_\_\_\_\_  
 Difficulty drawing or copying \_\_\_\_\_  
 Difficulty dressing \_\_\_\_\_  
 Difficulty doing things I used to do automatically (e.g., brushing teeth) \_\_\_\_\_  
 Difficulty find way around familiar places \_\_\_\_\_  
 Difficulty recognizing objects or people \_\_\_\_\_  
 Difficulty decline in my musical abilities \_\_\_\_\_  
 Not aware of time \_\_\_\_\_  
 Slowed reaction time \_\_\_\_\_  
 Other nonverbal problems? \_\_\_\_\_

*Awareness and Concentration*

Highly distractible \_\_\_\_\_  
 Lose my train of thought easily \_\_\_\_\_  
 Mind goes blank a lot \_\_\_\_\_  
 Difficulty doing more than one thing at a time \_\_\_\_\_  
 Easily confused and disoriented \_\_\_\_\_  
 Don't feel very alert or aware of things \_\_\_\_\_  
 Tasks require more effort or attention \_\_\_\_\_

*Memory*

Forget where I leave things (e.g., keys, purse, etc.) \_\_\_\_\_  
 Forget names \_\_\_\_\_  
 Forget what I should be doing \_\_\_\_\_  
 Forget where I am or where I am going \_\_\_\_\_  
 Forget recent events \_\_\_\_\_  
 Forget appointments \_\_\_\_\_  
 Forget events that happened long ago \_\_\_\_\_  
 Forget the order of events \_\_\_\_\_  
 Forget facts but can remember how to do things \_\_\_\_\_  
 Forget faces of people I know \_\_\_\_\_  
 More reliant on others to remind me of things \_\_\_\_\_  
 More reliant on notes to remember things \_\_\_\_\_  
 Other memory problems? \_\_\_\_\_

**Date of Onset**

**Mood/Personality**

Sadness and depression \_\_\_\_\_  
 Anxiety or nervousness \_\_\_\_\_  
 Stress \_\_\_\_\_

Sleep problems \_\_\_\_\_  
 Excessive snoring \_\_\_\_\_  
 Become angry more easily \_\_\_\_\_  
 Euphoria (feeling on top of the world) \_\_\_\_\_  
 Much more emotional \_\_\_\_\_  
 Feel as if I just don't care anymore \_\_\_\_\_  
 Easily frustrated \_\_\_\_\_  
 Less inhibited (do things I would not do before) \_\_\_\_\_  
 Difficulty being spontaneous \_\_\_\_\_  
 Change in energy? | Loss | Gain \_\_\_\_\_  
 Change in appetite? | Loss | Gain \_\_\_\_\_  
 Change in weight? | Loss | Gain \_\_\_\_\_  
 Change in sexual interest \_\_\_\_\_  
 Lack of interest in pleasurable activities \_\_\_\_\_  
 Increase in irritability \_\_\_\_\_  
 Increase in aggression \_\_\_\_\_  
 Other changes in mood or personality or in how you deal with people? \_\_\_\_\_

Overall, my symptoms have developed? Slowly Quickly

Over the past six months my symptoms have: improved stayed the same worsened

Is there anything you can do (or someone does) that gets the problems to stop or be less intense, less frequent, or shorter? \_\_\_\_\_

What seems to make the problem worse? \_\_\_\_\_

Please indicate if you have a history of any of the following. If yes, please briefly describe:

**Yes No** Head injury? \_\_\_\_\_  
**Yes No** Hypertension/High Cholesterol? \_\_\_\_\_  
**Yes No** Heart Disease? \_\_\_\_\_  
**Yes No** Stroke? \_\_\_\_\_  
**Yes No** Seizure? \_\_\_\_\_  
**Yes No** Neurological Disorder? (such as Parkinson's disease)? \_\_\_\_\_  
**Yes No** Cancer? \_\_\_\_\_  
**Yes No** Headaches? \_\_\_\_\_  
**Yes No** Diabetes/Kidney Problems? \_\_\_\_\_  
**Yes No** Surgeries? \_\_\_\_\_  
**Yes No** Other (e.g., thyroid problem, menopause, etc)? \_\_\_\_\_

Have others commented to you about changes in your thinking, behavior, personality, or mood? If so, who, and what have they said? \_\_\_\_\_

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Please list your current medications, including dosage and approximate start date: \_\_\_\_\_

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Please list any medical or psychiatric diseases that run in your family: \_\_\_\_\_

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How is your mood? \_\_\_\_\_

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Do you have a history of psychiatric illness? \_\_\_\_\_

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Have you ever been treated for a psychiatric problem? If yes, how? \_\_\_\_\_

### **Family History**

The following questions deal with your biological mother, father, brothers, and sisters:

Is your mother alive? | Yes | No                      Mother's highest level of education: \_\_\_\_\_

If deceased, what was the cause of her death? \_\_\_\_\_

Is your father alive? | Yes | No                      Father's highest level of education: \_\_\_\_\_

If deceased, what was the cause of his death? \_\_\_\_\_

Please describe any parental family history of:

Neurological diseases (e.g., Parkinson's, Alzheimer's, multiple sclerosis): \_\_\_\_\_

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Psychiatric conditions (e.g., depression, anxiety, bipolar illness, schizophrenia): \_\_\_\_\_

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Other disorders (e.g., problems with attention, learning, speech/language, or behavior): \_\_\_\_\_

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How many brothers and sisters do you have and what are their ages? \_\_\_\_\_

Are there any unusual problems (physical, academic, psychological) associated with any of your brothers or sisters? If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

**Social and Occupational History**

Grade/degree completed in school: \_\_\_\_\_

Were you involved in special education? \_\_\_\_\_

Are you married? | Yes | No How long? \_\_\_\_\_

With whom do you currently live? \_\_\_\_\_  
\_\_\_\_\_

Do you have children? Ages? \_\_\_\_\_  
\_\_\_\_\_

Are you unemployed, employed, or retired? \_\_\_\_\_  
\_\_\_\_\_

Describe any legal problems you have had: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How do you spend your time? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there any other information you would like to add? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_