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Neuropsych Initial History Form – Adult Patients

General Information

Patient's Full Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Handedness: R L Ambidextrous

Person Completing this Form (if other than patient): _____ Relationship to Patient: _____

Phone Numbers: Home _____ Work _____ Cell/mobile _____

Complete address: _____

Name and phone number of primary care physician: _____

Name and phone number of specialist: _____

Who referred you for neuropsychological evaluation? _____

Name/contact info for attorney if referral is related to legal proceedings: _____

Please list the reason(s) for your visit: _____

General Medical History

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

List your current medications, including dosage and approximate start date: _____

Describe any history of psychiatric illness you have had, including any psychiatric treatment _____

Describe any past and current use of alcohol, tobacco, and recreational drugs: _____

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

Symptom Survey - Please check each symptom that applies, and note date of onset if possible:

Physical concerns

Date of Onset

- | | |
|---|-------|
| <input type="radio"/> Headaches | _____ |
| <input type="radio"/> Dizziness | _____ |
| <input type="radio"/> Balance problems | _____ |
| <input type="radio"/> Urinary problems | _____ |
| <input type="radio"/> Bowel problems | _____ |
| <input type="radio"/> Strength problems | _____ |
| <input type="radio"/> Motor problems | _____ |

Other physical concerns? _____

Motor and Coordination

This occurs on your:

	Right side	Left side	Both sides
<input type="radio"/> Fine motor problems (managing buttons, pencil, utensils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Weakness on one side of body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Difficulty holding on to things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Tremor or shakiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Muscle tics or strange movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Writing is very small	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Writing is very large	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Walking more slowly than other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Balance problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Difficulty starting to move	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Jerky muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Muscles tire quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Often bumping into things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Other motor or coordination problems: _____			

Sensory

Date of Onset

<input type="radio"/> Numbness	_____
<input type="radio"/> Tingling	_____
<input type="radio"/> Visual problems	_____
<input type="radio"/> Wear glasses/contact lenses	_____
<input type="radio"/> See things that are not there	_____
<input type="radio"/> Hearing problems	_____
<input type="radio"/> Wear hearing aid	_____
<input type="radio"/> Problems with taste or smell	_____
Other sensory concerns? _____	

Neurocognitive/Information Processing

Problem Solving

Date of Onset

<input type="radio"/> Difficulty figuring out how to do new things	_____
<input type="radio"/> Difficulty figuring out problems that most others can do	_____
<input type="radio"/> Difficulty planning ahead	_____
<input type="radio"/> Difficulty changing a plan or activity when necessary	_____
<input type="radio"/> Difficulty thinking as quickly as needed	_____
<input type="radio"/> Difficulty doing things in the right order (sequencing)	_____
Other problem solving problems? _____	

Language and Math Skills

Date of Onset

<input type="radio"/> Difficulty finding the right word	_____
<input type="radio"/> Slurred speech	_____
<input type="radio"/> Difficulty expressing thoughts	_____
<input type="radio"/> Difficulty understanding what others say	_____
<input type="radio"/> Difficulty understanding what you read	_____
<input type="radio"/> Difficulty writing letter or words (not due to a motor problem)	_____
<input type="radio"/> Difficulty with math (e.g., balancing checkbook, making change)	_____
Other language or math problems? _____	

Nonverbal skills

Date of Onset

<input type="radio"/> Difficulty telling right from left	_____
<input type="radio"/> Difficulty drawing or copying	_____
<input type="radio"/> Difficulty dressing	_____

- Difficulty doing things you 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/lose track of time _____
 - Slowed reaction time _____
- Other nonverbal problems? _____

Concentration/Awareness

Date of Onset

- Highly distractible _____
 - Lose 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 _____
- Other related problems? _____

Memory

Date of Onset

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

Mood/Personality

Date of Onset

- 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 you just don't care anymore _____
- Easily frustrated _____
- Less inhibited (do things you 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/personality or in how you interact with people? _____

Overall, symptoms have developed..... Slowly Quickly Not sure

Over the past 6 months, symptoms have..... Improved Stayed the same Worsened Not Sure

Please indicate if **you** have a history of any of the following. If yes, please describe and include dates of onset:

Yes No Head injury _____
Yes No Hypertension/High Cholesterol _____
Yes No Heart Disease _____
Yes No Stroke _____
Yes No Seizure/Epilepsy _____
Yes No Neurological Disorder (e.g., Parkinson's, Dementia) _____
Yes No Cancer _____
Yes No Diabetes _____
Yes No Surgeries _____
Yes No Other (e.g., thyroid, autoimmune, menopause) _____

Have others commented on changes in your thinking, behavior, personality, or mood? Yes No Who, & what have they said? _____

Social and Occupational History

Highest grade/degree you completed in school: _____

Did you require special education? _____

What is your current work status? Unemployed Employed Retired

Past and current occupations _____

Are you married? Yes No For how long (list all marriages)? _____

With whom do you currently live? _____

Do you have children? Yes No What are their ages? _____

Describe any legal problems you have had: _____

How do you spend your time? _____

Family History – Please describe any **family** history of:

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

Psychiatric conditions (e.g., depression, anxiety, bipolar, schizophrenia): _____

Other disorders (e.g., attention deficits, intellectual/learning, speech/language, behavior): _____

Any Additional Comments: _____