NEUROPSYCHOLOGY HISTORY FORM - ADULT

Name: _____ Today's Date: _____Age: _____
Date of Birth:_____ Marital Status: _____ Handedness: R L Both

Race: _____ Country of origin _____ Is English your first language? Y N

Home Address:
_____

Who is completing this form (self, spouse, etc)?
_____

Highest level of education: _____ Occupation _____

	Yes	No
working?	☐	☐
Disabled?	☐	☐
Retired?	☐	☐

Have you ever had a neuropsychological / cognitive evaluation? Y N
If so, when and with whom?

Referral Information:

Who referred you to us? _____ Next Apt
_____

To whom would you like the report sent?

Name:_____ Name: _____
Address:_____ Address: _____
_____ _____
Phone Number: _____ Phone Number: _____

Do you have a healthcare proxy / power of attorney? YES NO

If yes, who _____

Briefly describe the problems with your thinking / functioning that bring you here:

14 Technology Drive, Suite 12B, East Setauket, NY 11733
181 Belle Mead Road, Suite 4, East Setauket, NY 11733
240 Middle Country Road, Smithtown, NY 11787
TEL: 631-444-8053 FAX: 631-444-4267

_____
_____
_____
_____

Specific examples of my thinking (cognitive) problems:

_____
_____
_____
_____

Approximately when did these problems first start?

_____

These problems started: ___GRADUALLY ___SUDDENLY ___NOT SURE

Since starting, these problems are: ___IMPROVING ___WORSENING ___STAYING THE SAME

Have you experienced any of the following?

Significant changes in your health	Yes	No
Changes related to physical functioning (e.g., falls, tremor)	Yes	No
Changes in mood or level of stress	Yes	No
Difficulty with basic daily tasks (e.g., dressing, grooming, bathing)	Yes	No
Difficulty completing functional daily tasks:		
Managing medications	Yes	No
Cooking	Yes	No
Managing appointments	Yes	No
Driving	Yes	No
Managing finances (e.g., balancing checkbook)	Yes	No
Managing household	Yes	No

CURRENT MEDICATIONS (include dosages and non-prescription medications):

Name	Dose	Name	Dose

MEDICAL HISTORY: Do you have any of the following (Check the appropriate boxes):

☐ High blood pressure
☐ High cholesterol
☐ Heart disease/ heart attack
☐ Stroke/ Mini-stroke
☐ Diabetes
☐ Kidney disease
☐ Thyroid disease
☐ HIV/AIDS
☐ Liver disease
☐ Seizures
☐ Cancer (indicate type) _____
☐ COPD
☐ Lyme Disease
☐ Headache
☐ Chronic Pain
☐ Arthritis
☐ Vision problems
☐ Bowel/ Bladder Incontinence
☐ Falls
☐ Tremors
☐ ADHD Diagnosis
☐ Learning disability diagnosis
☐ MS / Lupus / Autoimmune related disorder

For Females only:

☐ Problems related to menstruation (sleep, pain, mood/ thinking changes)
☐ If menopausal/ post-menopausal, problems related to sleep, pain, or thinking/ mood
☐ Hormone replacement therapy

List major surgeries:

_____

_____

Have you ever had a head injury? Y N If yes, please describe:

_____

_____

Do you have any of the following sleep problems :

☐ Snoring
☐ Wake gasping for air
☐ Sleep apnea
☐ Wake with sore throat/ headache
☐ Wake not feeling rested
☐ Sleep walking
☐ Insomnia
☐ Restlessness
☐ Nightmares

Have you ever had any of the following :

☐ MRI/ CT/ PET (brain scan)
☐ MRA
☐ EEG (brain wave)

What were the results of the above?

_____

Any recent changes in appetite, energy, fatigue, or pain? Y N If yes, describe:

_____

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In the past 7 days:

How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

How likely are you to doze off during the day?

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

How would you rate your fatigue on average?

None	Mild	Moderate	Severe	Very Severe
1	2	3	4	5

How much stress have you experienced on average?

None	Mild	Moderate	Severe	Very Severe
1	2	3	4	5

How would you rate your pain on average?

No Pain										Worst Pain Imaginable
0	1	2	3	4	5	6	7	8	9	10

MENTAL HEALTH HISTORY: Have you had any of the following (check all that apply):

☐ Depression
☐ Anxiety
☐ Panic attack
☐ Eating disorder
☐ Bipolar disorder
☐ Hearing voices
☐ Visual Hallucinations
☐ ADHD/ ADD
☐ Substance Abuse/ dependence
☐ Trauma
☐ ECT (Electro-convulsive therapy)
☐ TMS

Age when did you first receive treatment? _____ By whom:_____ Type of clinician:_____

Are you currently in treatment? Y N Name of current clinician:_____

Current mood:

_____

Have you ever been hospitalized for mental health problems? Y N Age:____
Hospital:_____

Do you have current thoughts of hurting yourself or ending your own life? Y N

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Do you have a history of drug or alcohol use? Y N If yes, describe:
_____

History of DUI/DWI? _____
Have you/ do you use opioids? _____
How many alcoholic beverages do you have each week? _____
Have you ever drunk more than this? _____
When was the last time you smoked marijuana? _____
Do you smoke tobacco? Y N If yes, how much? _____ For how many years?
_____
How many caffeinated beverages do you drink each day?_____

DEVELOPMENTAL, EDUCATIONAL AND OCCUPATIONAL HISTORY:

Were there any problems with your mother's pregnancy with you or birth? _____
Were there any delays in speech/ motor abilities? _____

Were there any difficulties in school (Academically/ socially/ behaviorally)?
_____
_____
_____
_____

☐ Attention/ Learning Difficulty
☐ Reading/ Writing/ Math/ Coordination Difficulty
☐ Special Education services (e.g., IEP or 504 Plan)

If you went to college, where did you go? _____
What was your major? _____

If you attended Graduate/professional School, where did you go?
_____

What was your field of major? _____ Graduated: Y N

Are you currently employed? Y N Retired

If yes, please describe your work _____

If no, what was the nature of the last job you had? _____

If retired, when? _____

CURRENT:
Whom do you live with?_____
Nature of your relationship_____

Any home life stressors? (For example; significant medical, psychiatric or drug problems within the home, financial stressors)

_____

What are your interests or hobbies?

_____

Do you exercise regularly? Y N Describe:

_____

LEGAL ISSUES:

Have you had any of the following?

☐ Arrests
☐ Legal difficulty
☐ Working with an attorney
☐ Have applied for disability in the past
☐ OMH Services
☐ Divorce/ separation
☐ OPWDD Services
☐ Applying for disability
☐ Receiving disability

If yes to any legal question, describe:

_____
_____

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FAMILY HISTORY (Please provide complete information)

	Age	Age of Death	Education/Occupation	Medical / Psychiatric / Learning Disorder History
Mother				
Father				
Brothers				
Sisters				
Children				

Family history (If not described above):

☐ High blood pressure
☐ High cholesterol
☐ Heart disease/ heart attack
☐ Stroke/ Mini-stroke
☐ Diabetes
☐ Kidney disease
☐ Thyroid disease
☐ Liver disease
☐ Cancer (indicate type) _____
☐ COPD
☐ Chronic Pain
☐ MS/ lupus/ Autoimmune related disorder
☐ ADHD/ Learning disability
☐ Depression/ Anxiety
☐ Auditory or visual hallucinations
☐ Bipolar disorder
☐ Drug/ Alcohol abuse or dependence
☐ Seizures
☐ Dementia (Alzheimer's/ Parkinson's)

If there is any other information that you feel is important for us to know about you, please write it below:_____

_____

_____

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