Stony Brook Medicine

NEUROPSYCHOLOGY HISTORY FORM - ADULT

Name: _____ Today's Date: _____ Age: _____

Date of Birth: _____ Marital Status: _____ Handedness: -select here-

Race: _____ Country of Origin: _____ Is English your first language? _____

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? -select here- __

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: _____

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

_____

_____

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

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? -select- 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 procedures?
☐ 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? -select- If yes, describe: _____

_____

In the past 7 days:

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

-select below-

How likely are you to doze off during the day?

-select below-

How would you rate your fatigue on average?

-select below-

How much stress have you experienced on average?

-select below-

How would you rate your pain on average?

-select below-

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 received treatment? _____ By whom: _____ Type of clinician: _____

Are you currently in treatment? -select- Name of current clinician: _____

Current mood: _____

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

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

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

_____

History of DUI/DWI? _____

How many alcoholic beverages do you have each week? _____ Have you ever drunk more than this? _____

Have you/ do you use opioids? _____ When was the last time you smoked marijuana? _____

Do you smoke tobacco? ____ 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? _____ Graduated: _____

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

What was your field of major? _____ Graduated: _____

Are you currently employed? _____ If yes, please describe your work _____

If not currently working, what was the last job you had? _____ If retired, when? _____

CURRENT LIVING SITUATION:

Whom do you live with? _____ Nature of your relationship_____

Any home life stressors? (such as financial stressors or significant medical/psychiatric problems within home)

_____

What are your interests or hobbies? _____

Do you exercise regularly? -select- Describe: _____

LEGAL ISSUES:

Have you had any of the following?

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

If yes to any legal question, describe: _____

_____

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:

_____

_____

_____