NEUROPSYCHOLOGY HISTORY FORM - ADULT

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

Date of Birth: _____Age: _____ Gender:_____ Marital Status: _____

Race: _____ Ethnicity: _____Country of origin: _____

Is English your first language? Y N Handedness: R / L / Both

Home Address: _____

Phone:_____ Email Address:_____

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

	Yes	No
Working?	☐	☐
Disabled?	☐	☐
Retired?	☐	☐

Highest level of education: _____ Occupation _____

Have you ever had a neuropsychological / cognitive evaluation? Y N

If so, when and with whom? _____

Referral Information:

Who referred you to us? _____ Next Appt:_____

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:

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)—or Attach med sheet:

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
☐ COVID-19 infection: If yes, date _____
☐ Do you feel you have cognitive symptoms related to COVID-19: ☐ Yes ☐ No

☐ Lyme Disease
☐ Headache
☐ Chronic Pain
☐ Arthritis
☐ Vision problems
☐ Bowel/ Bladder Incontinence
☐ Falls
☐ Tremors
☐ ADHD Diagnosis
☐ Learning disability diagnosis
☐ MS / Lupus / Autoimmune related disorder

☐ 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 concussion/brain injury? Y N If yes, what year/s_____

Do you have any history of loss of consciousness related to a concussion/head injury? Please describe all concussions/head injuries:

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:

☐ Magnetic Resonance Imaging (MRI) of brain
☐ Computed Tomography (CT) of brain
☐ Positron Emission Tomography (PET) scan of brain
☐ Magnetic Resonance Angiography (MRA) of brain
☐ Electroencephalography (EEG, brain wave)

What were the results of the above?

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

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 use disorder
☐ Trauma
☐ ECT (Electroconvulsive therapy)
☐ TMS (Transcranial Magnetic Stimulation)

Age when you first received 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

Do you have a history of drug or alcohol use? Y N

If yes,describe:_____

How many alcoholic beverages do you have each week? _____

Largest number of drinks consumed at one time? _____ History of DUI/DWI? _____

Do you use marijuana? Y / N How often? _____ Opioids? Y / N How often? _____

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/Self-Control Problems
☐ 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, and for how long?_____ Nature of 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 / SOCIAL SERVICE ISSUES:

Have you had any of the following?

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

If yes to any legal / social services question, describe: _____

FAMILY HISTORY (Please provide complete information)

	Age	Age at 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: