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Please bring this completed form to your appointment

Patient Name: _____

Name of person filling out this form (if not patient): _____

Relationship to patient: _____

Have you ever had a prior neuropsychological evaluation? ☐ Yes ☐ No

What hand do you write with? ☐ Right hand ☐ Left hand Gender: _____

Race/Ethnicity: _____ Native language: _____

Reason for appointment

What particular problem(s) brings you to the doctor? _____

_____

Approximate date of onset: _____

Please check each symptom that you are **currently** experiencing:

Memory & Thinking

☐ Problems making decisions or solving problems
☐ Problems finding the right word or name
☐ Problems understanding what I read
☐ Problems with multi-tasking
☐ Forgetting where I put things
☐ Repeating myself
☐ Forgetting what I read
☐ Forgetting appointments
☐ Making mistakes with bills
☐ Problems with organization
☐ Problems following instructions
☐ Problems with attention or concentration
☐ Slowed thinking or reactions
☐ Forgetting what people tell me
☐ Forgetting names
☐ Getting easily lost driving
☐ Making mistakes with medications
☐ other: _____

Please check each symptom that you are **currently** experiencing:

Motor & Coordination

- ☐ Difficulty with coordination
- ☐ Tremor or shakiness
- ☐ Balance or walking problems
- ☐ Falling
- ☐ other: _____

Sensory

- ☐ Changes in vision
- ☐ Changes in smell or taste
- ☐ Changes in hearing
- ☐ Ringing in the ears
- ☐ Seeing or hearing things that aren't really there
- ☐ Numbness or tingling
- ☐ other: _____

Physical

- ☐ Headaches
- ☐ Dizziness
- ☐ Chronic pain
- ☐ Urinary incontinence
- ☐ Frequent fatigue
- ☐ Sleep problems
- ☐ Change in eating habits
- ☐ other: _____

Behavior & Mood

- ☐ Sadness or depression
- ☐ Anxiety or nervousness
- ☐ Feeling more emotional, crying more easily
- ☐ Being angry or irritable more easily
- ☐ Under a lot of stress
- ☐ Thoughts of suicide
- ☐ other: _____

PAST MEDICAL HISTORY

Please check all medical conditions for which you are (or have been) treated:

- ☐ HIV/AIDS
- ☐ Anxiety
- ☐ Stroke or TIA
- ☐ Brain infection
- ☐ Bipolar Disorder
- ☐ Sleep apnea
- ☐ Brain tumor
- ☐ Panic Attacks
- ☐ Seizures
- ☐ Cancer or chemotherapy
- ☐ Schizophrenia
- ☐ Radiation exposure
- ☐ Hazardous substance exposure
- ☐ Meningitis
- ☐ High blood pressure
- ☐ Huntington's disease
- ☐ Hypoxia/anoxia
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Heart problems
- ☐ Depression
- ☐ Concussion/head injury
- ☐ Brain surgery
- ☐ other: _____

Have you EVER been treated for depression, anxiety, or other problems with mood or mental health with either medications or counseling? ☐ Yes ☐ No

Have you ever had neuroimaging studies (Brain MRI, head CT scan, and/or EEG)? ☐ Yes ☐ No
If yes, please list the approximate dates and the results:_____

_____

What medications are you currently taking? _____

_____

_____

FAMILY MEDICAL HISTORY

Does anyone related to you have these conditions? (Check all that apply)

☐ Alzheimer's disease	☐ Multiple Sclerosis	☐ Seizures
Relationship: _____	Relationship: _____	Relationship: _____
☐ Parkinson's disease/tremor	☐ Stroke(s)	☐ Depression
Relationship: _____	Relationship: _____	Relationship: _____
☐ Bipolar disorder	☐ Anxiety	☐ Dementia
Relationship: _____	Relationship: _____	Relationship: _____

EARLY LIFE HISTORY

You were born: ☐ On time ☐ Prematurely ☐ Late ☐ I don't know

Were there any problems with your birth? ☐ Yes ☐ No If yes, what kind: _____

As a CHILD, did you have any of these problems? (Check all that apply)

☐ Developmental delay	☐ Attention problem	☐ Hyperactivity
☐ Speech problem	☐ Learning problem	☐ Head injury

EDUCATIONAL HISTORY

Highest grade or degree earned and name(s) of college/university, if applicable:

_____

Circle the grade range typical for you when you were in school: A B C D F

Were you ever held back to repeat a grade? ☐ Yes ☐ No

Were you ever in any special class(es), or did you ever receive special services? ☐ Yes ☐ No

MILITARY HISTORY

Have you ever served in the military? ☐ Yes ☐ No

EMPLOYMENT HISTORY

Are you currently working? ☐ Yes ☐ No ☐ Retired ☐ Disabled ☐ Medical Leave

Are you currently pursuing disability benefits? ☐ Yes ☐ No

Primary occupation (current or previous): _____

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Separated ☐ Divorced
☐ Widowed ☐ Single ☐ Significant Other

Do you have children? ☐ Yes ☐ No If yes, number of children: _____

SUBSTANCE USE

Do you currently drink alcohol? ☐ Yes ☐ No If yes, number of drinks per week:_____

Do you currently use illegal or recreational substances? ☐ Yes ☐ No

Have you ever been treated for drug or alcohol abuse or dependence? ☐ Yes ☐ No

Do you currently smoke cigarettes? ☐ Yes ☐ No If yes, number of cigarettes per day:_____

LEGAL HISTORY

Are you currently involved in any civil or criminal cases? ☐ Yes ☐ No

Do you have a history of being arrested or charged with a crime? ☐ Yes ☐ No