

NEUROPSYCHOLOGICAL HISTORY

PATIENT'S NAME _____ DATE _____

NAME OF PERSON FILLING OUT THIS FORM (if NOT patient) _____

(Indicate your relationship to patient) _____

I. IDENTIFYING INFORMATION:

DOB _____ AGE _____ RIGHT-HANDED OR LEFT-HANDED? _____

(Any family members left-handed? _____)

PLACE OF BIRTH _____ RAISED IN _____

FATHER'S OCCUPATION: _____ MOTHER'S OCCUPATION: _____

MOVED HERE IN _____ NO. OF BROTHERS (ages) _____ SISTERS _____

PRIMARY CHILDHOOD LANGUAGE (if not English, note when learned English) _____

EDUCATION (Circle years of formal ed. completed) <7 8 9 10 11 12 13 14 15 16 17 18 19 20+

Circle highest awarded: G.E.D. H.S. Dipl. AA BA/BS MA/MS Doctorate Professional

Year and field of college degree(s) _____

Ever held back in a grade? _____

Ever in special ed. classes? (note subjects) _____

Learning problems? Reading _____ Spelling _____ Math _____

MILITARY SERVICE: Date In Date Out Rank Duties

Branch _____

Combat? (note places) _____ Injuries? _____

SOCIAL SECURITY DISABILITY OR OTHER DISABILITY? (Note cause) _____

MARITAL STATUS (Record dates of each marriage/reason ended/number & sexes of children):

EMPLOYMENT HISTORY (note principal types of employment, years in each type):

<u>Job Title/Type of Work</u>	<u>Dates</u>	<u>Job Title/Type of Work</u>	<u>Dates</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Retired? Yes No Date _____ Reason _____

Unemployed for other reason (indicate) _____

CURRENT SOURCES OF FINANCIAL SUPPORT _____

CURRENT LEISURE ACTIVITIES _____

II. MEDICAL HISTORY: For each applicable illness/condition, record the date of diagnosis or onset of disease or of any injuries.

Did the patient experience any birth complications/neonatal illness or injury?

Does the patient now have, or has the patient ever had, any of the following:

Alzheimer's Disease _____

Anoxia/Artificial Respiration _____

Arteriosclerosis _____

Arthritis/Gout (note parts of body involved) _____

Brain Tumor (note location) _____

Broken Limbs _____

Cancer (note type) _____

Coma (note cause) _____

Diabetes (On insulin--Yes ___ No ___ For how long? _____)

Fever over 105 degrees _____

Headaches: Frequency-- _____ Duration-- _____

Location-- _____ When first began-- _____

Head Injury:

<u>Date</u> and <u>Cause</u>	<u>Unconscious?</u>	<u>If so, for how long?</u>
_____	Y ___ N ___	_____
_____	Y ___ N ___	_____
_____	Y ___ N ___	_____

Heart Disease _____

High Voltage Accident _____

Huntington's Disease _____

Hydrocephalus _____

Hypertension _____

Hypoglycemia _____

Kidney Disease _____

Liver Disease _____

Meningitis/Encephalitis _____

Multiple Sclerosis _____

Paralysis _____

Parkinson's Disease _____

Psychiatric/Emotional Problems _____

Respiratory Disease _____

Seizures (note type if known, date of last seizure) _____

Sensory Change/Loss _____

Sexually Transmitted Diseases _____

Sleep Disorder _____

Spinal Problems _____

Stroke (note locations/side of body affected/symptoms) _____

Surgeries:

<u>Type</u>	<u>Date</u>	<u>Type</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Syncope (blackouts/fainting) _____

Thyroid Disorder _____

Toxic Chemical Exposure _____

Valley Fever _____

Other _____

CURRENT MEDICATIONS: _____

SUBSTANCE USE: Any DUI offenses? (Approximate number) _____

Alcohol—How often do you drink alcohol? _____ How much? _____

Previous problem with alcohol? Yes ___ No ___ Drinker from age ___ to age ___

Treatment: Outpatient (e.g., AA) _____

Inpatient _____

Illicit Drugs--(note types, dates): _____

Tobacco--(age started, age stopped, amount): _____

FAMILY MEDICAL HISTORY:

<u>Relative</u>	<u>Age</u>	<u>Current Health Status or Cause of Death</u>
Mother	_____	_____
Father	_____	_____
Maternal GF	_____	_____
Maternal GM	_____	_____
Paternal GF	_____	_____
Paternal GM	_____	_____
Brothers/Sisters	_____	_____

Please note any diseases that run in patient's family:

Able to drive? Yes___ No___ If not, what are the problems?

Having any problems with memory? If so, please describe and indicate when problem(s) began.

Please note below anything else that you think it is important for the neuropsychologist to know.
