NEUROPSYCHOLOGICAL HISTORY

Name: _____Date:_____

Name/relationship of person completing form (if other than client):_____

GENERAL DEVELOPMENT HISTORY:

Describe any unusual illness, conditions, accidents, or drug/alcohol exposure during your mother's pregnancy with/delivery of you:_____

Were you healthy as an infant? Yes No If No, explain_____

Describe any delays in meeting your developmental milestones (e.g., crawling, walking, speaking, toilet training):_____

EDUCATIONAL HISTORY:

Highest grade/degree completed:_____

Describe any learning problems, including grade retentions/special educational services:_____

_____

SOCIAL HISTORY:

Marital Status: Married Divorced Never Married Widowed Other:_____

Children: Y N If Yes, Number of Children and Ages _____

Who lives in the household with you:_____

Where do you live and for how long (i.e., apartment, own home, mobile home)_____

MEDICAL HISTORY

Please check any medical problems for which you are CURRENTLY being treated:

__High blood pressure __High cholesterol __Diabetes __Heart disease

__Obstructive sleep apnea __Hypothyroidism __Kidney disease __Multiple Sclerosis

__Asthma __Allergies __Vitamin deficiency (describe)_____

__Chronic pain (describe)_____ __Cancer (describe)_____

History of stroke?_____ History of seizures?_____

History of head injury?_____ History of heart attack?_____

Other relevant medical history:_____

List dates/types of surgical procedures_____

Name of primary care physician_____

Are you followed by any specialists?_____

Current medications

Name	Dose	Taken for what condition	Taken for how long
1._____			
2._____			
3_____			
4._____			
5._____			
6._____			
7._____			

Other current medications (names and doses):_____

Do you smoke tobacco? Y N If yes, how many packs per day:_____

Describe your current alcohol use (type, how much, how often): _____

Describe current street drug use (type, how much, how often):_____

Do you have history of alcohol or drug abuse? Y N Have you ever been treated for substance abuse? Y N

PSYCHIATRIC HISTORY:

Have you ever had a neuropsychological evaluation before? Y N If yes, what year?_____

Are you seeing a counselor/therapist at this time? Y N If yes, name:_____

Are you seeing a psychiatrist at this time? Y N If yes, name:_____

Have you ever received psychiatric care (therapy, medication, or hospitalization)?_____

OCCUPATIONAL HISTORY:

Current occupational status: Full-time work Part-time work Retired Disabled Other:_____

What work do you do currently or what did you do in your last job?_____

CURRENT FUNCTIONING (check all that apply):

__Have a legal guardian __Have a durable power of attorney that has been enacted __Have a rep payee

__Need help managing medications __Need help managing finances __Cannot drive

__Need help with showering/dressing __Need help with preparing meals __Need help managing household

Current symptoms (check all that apply):

__Depressed __Irritable __Angry __Exuberant/joyous __ Decreased interest in activities
__Weight loss __Weight gain __Racing Thoughts __Spending sprees __Increased risk-taking
__Nightmares __Fears/worries __Flashbacks __Easily distracted __Jumpy

__Sleep problems __Restlessness __Delusions/unusual beliefs
__Repetitive/unusual behavior __Fatigue/loss of energy __Increased energy
__More talkative __Fixations/obsessions __Compulsive behavior
__Hallucinations __Suicidal thinking __Change in alcohol/drug use
__Verbal aggression __Physical aggression __Sexual acting out

__Changes in vision __Changes in smell/taste __Changes in hearing
__Tremor __Changes in walking __Balance problems
__Falls __Incontinence __Changes in sleep
__Restless legs syndrome __Confusion __Fluctuations in ability

__Misplacing objects __Difficulty following instructions __Forgetfulness
__Difficulty concentrating __Fidgety/squirmy __Changes in speech
__Difficulty waiting/turn-taking __Forgetting names __Getting lost
__Losing temper __Not recognizing people you know __Difficulty starting projects
__Difficulty finishing tasks __Difficulty making decisions __Difficulty with organization
__Difficulty solving problems __Impulsive __Changes in personality

Other symptoms/concerns that led you to this evaluation:_____

_____

What question(s)/goals are you hoping to answer/meet with this evaluation?_____

_____