Dr. B. Buchanan, PhD – Clinical Psychologist/Neuropsychologist

Neuropsychological Exam Intake Form

For us to be able to fully evaluate you, we request you complete the following intake forms *completely*, to the best of your ability. We realize there is a lot of information, but every question is important. Please get assistance from a family member or person who knows you well, if necessary, to complete the forms accurately.

Name: _____ Date: _____

Date of Birth: _____ Age:_____ Education: _____ years

Telephone: _____ Email: _____

Dominant hand: ☐ Right ☐ Left ☐ Ambidextrous Ethnicity: _____

Referral Source: _____Preferred Pronouns: _____

Emergency Contact: _____ Phone #: _____

This form completed by: ☐ Self ☐ Other: _____

Reason for the evaluation:

_____

_____

_____

_____

Psychological/cognitive/emotional symptoms or problems you are currently experiencing:

_____

_____

_____

_____

_____

Are these symptoms improving, the same, or worsening? (circle one)

<u>Previous Medical History:</u>

Are you aware of any of the following during childhood? (If so, describe.)

Problems during prenatal development? ☐ Yes ☐No _____

Exposure to drugs or alcohol prenatally? ☐ Yes ☐No _____

Developmental delay in Speech/language? ☐ Yes ☐No _____

Motor Skills? ☐ Yes ☐No _____

Physical Development? ☐ Yes ☐No _____

Social Development? ☐ Yes ☐No _____

Other Serious Childhood Injury? ☐ Yes ☐No _____

Previous Surgeries of Hospitalizations:

_____

_____

COVID-19:

☐ Have you ever tested positive for COVID-19? ☐ Yes ☐ No If yes, when _____?

☐ Have you ever been exposed to someone with COVID-19? ☐ Yes ☐ No If yes, when_____?

☐ Are you vaccinated? ☐ Yes ☐ No Vaccine Brand_____ Boosted? ☐ Yes ☐ No

Previous Illness or injuries? (circle all that apply)

Stroke/TIA	Diabetes	Oxygen deprivation	Sleep apnea	Seizures	COPD
Gastrointestinal problems	Urinary / bowel problems	Hypothyroidism	Hypertension	Syncope	Migraines
Head injury / LOC	High fever	Hydrocephalus	Cancer	Falls/Imbalance	Other: _____

Psychiatric History: *Have you….*

Had any with mental health problems? ☐ Yes ☐ No Diagnosis? _____
Been hospitalized for psychiatric care? ☐ Yes ☐ No When? _____
Attempted suicide? ☐ Yes ☐ No If so, when? _____
Had counseling or therapy? ☐ Yes ☐ No Dates: _____ Was it helpful? ☐ Yes ☐ No
Do you hear or see things others do not? ☐ Yes ☐ No Describe: _____
History of abuse or trauma? ☐ Yes ☐ No Describe: _____

Sleep Behavior (check all that apply): ☐ sleepwalking ☐ nightmares ☐ recurrent dreams
☐ difficulty falling asleep ☐ wake up during the night ☐ difficulty getting up ☐ no problems
Time you lay down to sleep_____ PM Fall asleep_____ PM Wake up_____ AM
Average number of hours you sleep a night _____
How many times do you wake up during the night? _____
Are you able to fall back to sleep easily? ☐ Yes ☐ No
Do you feel rested when you wake up? ☐ Yes ☐ No
Do you take naps during the day? ☐ Yes ☐ No
Do you have sleep apnea? ☐ Yes ☐ No If so, when diagnosed? _____
Do you use a CPAP/BiPAP? ☐ Yes ☐ No

Appetite:

Any changes in appetite or weight? ☐ Increased ☐ Decreased ☐ No change
Glasses of water per day_____ Number of meals per day _____ Snacks per day _____
Caffeinated beverages per day _____ (tea/coffee/soda/energy drinks)
Problems swallowing? ☐ Yes ☐ No If so, for how long? _____

Alcohol, Tobacco and Drug History:

Alcohol: Current Use (Last 30 days): ☐ Yes ☐ No How Much: _____
Past Use: ☐ Yes ☐ No If yes, when did you quit? _____ Length of Use: _____
Tobacco: Current Use (Last 30 days): ☐ Yes ☐ No How Much: _____
Past Use: ☐ Yes ☐ No If yes, when did you quit? _____ Length of Use: _____
Drugs: Current Use (Last 30 days): ☐ Yes ☐ No Type of Drug: _____
Past Use: ☐ Yes ☐ No If yes, when did you quit? _____ Length of Use: _____
Has anyone told you they thought you had a problem with drugs or alcohol? ☐ Yes ☐ No
Have you felt guilty about your drug or alcohol use? ☐ Yes ☐ No

Ethnic/Cultural/Language/ Social Background:

Primary Language: _____
Marital Status: _____

Children (names and ages): _____

Hobbies: _____

Education History: Last grade *completed* _____ Average grades _____

Earned: ☐ GED ☐ HS diploma ☐ Some college ☐ Associate's ☐ Bachelor's ☐ Master's ☐ Doctorate

Name of College/University: _____ Major: _____

While in school: (check all that apply)

☐ Received accommodations through Special Education; Details: _____

☐ Diagnosed with learning disability; Details: _____

☐ Had behavioral problems; Details: _____

☐ Problems with learning or attention in school; Details: _____

☐ Academic problems in college; Details: _____

Occupational History: (Please list most current job and past jobs for PAST 5 YEARS.)

Job Employer Approximate Dates Reason for Leaving FT/PT

_____

_____

_____

_____

Military History: ☐ Yes ☐ No Branch: _____ Date of discharge: _____

Legal History:

Had you ever been arrested? ☐ Yes ☐ No If yes, give dates and charges: _____

Had you been incarcerated? ☐ Yes ☐ No If so, give dates: _____

Had you been on parole or probation? ☐ Yes ☐ No If yes, for how long? _____

Current Medications:

Medication, Supplements, or OTC	Dose	Date started	Is it beneficial? Circle one	List any side effects
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	