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Neuropsychological Evaluation Intake Packet

Medical and Psychological History

Notice to Patient: This personal history form is intended to help us gather all the information we need to help you. Everything is confidential and will not be released without your permission. Don't worry if you can't answer some of the questions, or if some do not apply to you. Just fill in the blanks as completely as you can and we will review the information with you during the initial consultation. PLEASE PRINT OR WRITE LEGIBLY. Thank you

Today's Date:_____

Name: _____ _____ _____
(First). (Middle Initial) (Last)

Date of Birth:_____. Age:_____ Gender: ☐Female ☐Male

Address_____City_____State_____ZIP_____

Cell Phone: (.)_____-_____. Home Phone: (.)_____-_____

Writing hand: ☐Right. ☐Left ☐Ambidextrous

Ethnicity:_____

Highest Level of Education:_____

Is English your first language? ☐Yes ☐No

If not, what is your first language?_____

Who referred you for this evaluation?_____

Have you ever had neuropsychological or psychological testing before? ☐Yes ☐No

If yes, by whom?_____

When?_____ Why?_____

HISTORY OF PRESENTING PROBLEM

Why are you being seen for a neuropsychological evaluation (e.g. I had a stroke, I got in a car accident and sustained a head injury; Family members say I have memory problems; etc.):

Date problem(s) began (estimate):_____

Course: ☐Getting Better. ☐Getting Worse. ☐Staying the Same

CURRENT PROBLEMS

Please check ALL Categories that apply. Each Category has samples to assist you in your selection.

☐Attention

Frequently missing details, making careless errors, difficulty paying attention for long periods of time, Easily distracted, Difficulty following instructions

☐Processing speed

Difficulty thinking quickly, Feeling as though most people talk too fast,Taking longer to complete tasks than before, Frequently asking people to repeat themselves (not due to hearing difficulty)

☐Learning and Memory

Difficulty remembering recent events, names, faces, the date, etc., Difficulty learning and remembering new information, Loss of long-term memories, Forgetting to take medication

☐Executive Functioning

Acting before thinking, Difficulty problem solving, or making bad decision, Difficulty following multi-step directions, Difficulty planning and organizing

☐Nonverbal/visual spatial skills

Getting lost in familiar locations, Problems Driving, Inappropriate use of objects (i.e. remote as hat), Right-Left or directional disorientation.

☐Speech & Language

The feeling that a word is on the tip of your tongue, Mislabeling items (ex. Clock vs. watch), Reduced speech volume, Difficulty understanding others or following conversations

☐Motor/Coordination

Difficulty buttoning a shirt, Difficulty opening medicine bottles, Difficulty with walking or balance/ recent falls, Shakiness/Tremor

☐Sensory

Reduced sense of smell, Tingling sensation, Loss of feeling in part of your body, Difficulty perceiving your bodies location in space

☐Physical Problems

Frequent headaches, Bowel or Bladder Incontinence, Dizziness, nausea, vomiting, Shortness of Breath, Sleep Disturbance/ Weight Change, Pain

☐Mood & Behavior

Increased irritability, Hallucinations (visual, auditory, or olfactory), Increased Sadness/ Crying for unknown reasons, Increase nervousness, suspiciousness, etc., Thoughts of harming yourself or taking your life, Discomfort in Social Situations

☐Recent Life Stressors

Change in job, Change in marital status, Death of loved one, Financial or legal problem, Moved to a new location,Taking care of aging or ill loved one

Please rate your overall stress level: □ Very Low □ Low. □ Average. □ High □ Very High

What is the greatest source of your stress at this time?

ACTIVITIES OF DAILY LIVING

Do you drive? □ Yes □ No

Who does the cooking at home? □ Myself □ Another Person

Do you manage your own finances? □ Yes □ No

Do you manage your own medications? □ Yes □ No

MEDICAL HISTORY

Please check the box to indicate any problems you have been identified as having and note (estimate) the year of diagnosis.

Neurologic:

□ Brain Injury
□ Brain Aneurysm
□ Migraines
□ Movement Disorder
□ Brain or Spinal Tumor
□ Stroke
□ Seizures
□ Dementia
□ Narcolepsy
□ Sleep Disorder
□ High Blood Pressure
□ High Cholesterol
□ Heart Disease/Heart Attack
□ Arteriosclerosis
□ Blood Disease (e.g., anemia) Genital-Urinary/ Gastro-Intestinal
□ Bowel or Bladder Incontinence
□ Colon Disease (e.g., Crohn's, IBS)
□ Regular Urinary Tract Infections
□ Gastroesophageal Reflux Disease
□ Pancreatitis
□ Liver Disease (e.g., hepatitis)

Oncology

□ Type & Site of cancer: _____

Mental Health

□ Anxiety Disorder
□ Mood Disorder (e.g., Depression, Bipolar)
□ Psychotic Disorder (e.g., Schizophrenia)

□ Substance Use Disorder
Endocrine
□ Diabetes
□ Hypoglycemia
□ Hypothyroidism
□ Hyperthyroidism (e.g., Graves)
□ Parathyroid Disorder
□ Adrenal Gland Disorder (e.g., Addisons)
□ Kidney Disorder
□ Cushing's Syndrome
□ Low Testosterone
□ Menopause
Ear, Nose, & Throat
□ Dizziness (e.g., vertigo, BPPV)
□ Chronic Ear Infections
□ Swallowing Disorder
□ Macular Degeneration
□ Cataracts or Glaucoma
Muscular-Skeletal
□ Amputation
□ Arthritis
□ Degenerative Joint Disease □ Osteoporosis
□ Fibromyalgia
□ Chronic Fatigue Syndrome
□ Genetic Type (e.g., Fragile X, Down Syndrome,
Mitochondrial Disease)_____
Have you had any blood work or imaging (e.g., CT, MRI, X-Ray) done in the past year?
□ Yes
If yes, what did you have
done:_____

Please list ALL medications you are currently taking
Medication.
Dose
How often do you take it
Reason

Psychological History

Have you EVER received treatment for depression, anxiety, or any other emotional difficulty?
Check all that apply:
□ Never received mental health treatment
□ Outpatient counseling
□ Inpatient psychiatric services
□ Pharmacological treatment (antidepressants, anti-anxiety medications, etc.)
Are you CURRENTLY receiving treatment for depression, anxiety, or other emotional difficulty?
□Yes □No
Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding:

FAMILY MEDICAL HISTORY

Please check any diagnoses that your immediate family members (blood relatives) have and indicate who.

DAIGNOSIS:	FAMILY MEMBER:
Dementia	
Seizures	
Movement Disorder (e.g., Parkinson's)	
Multiple Sclerosis	
Migraines	
Stroke	
Diabetes	
Hypertension	
Cancer	
Hyper-/hypothyroidism	
Genetic Disorder	
Learning Disability	
ADHD	
Schizophrenia	
Other:_____	

SOCIAL HISTORY

Where were you born?_____

Relationship Status: □ Single □ Married (Years Married:_____) □ Divorced □Widowed □ Other:

Do you have Children: □ Yes □ No

If yes, please list their ages:_____

Currently living in:

□ House. □Condo/Apartment. □Assisted Living Facility □ Nursing Home

OCCUPATIONAL/EDUCATION HISTORY

Level of Education

Name of School/Degree

Year Graduated

Typical Grades or GPA

Did you have any academic difficulty? □ Yes □ No

If yes, please answer the next 2 questions.

1. Did you repeat a grade? □ Yes □ No
2. Were you diagnosed with a learning Disability? □ Yes □ No

Employment Status: □ Employed □ Unemployed □ Retired. □ Disabled

If you are currently employed, please answer the next 3 questions.

1. Where do you work?_____

2. How long have you worked there?_____ 3. What's your Job title?_____
Did you serve in the Military? □ Yes □ No
If yes, Branch:_____ Years Served:_____
MOS:_____ Discharge Rank:_____ Type of Discharge:_____
Deployment History:_____

SUBSTANCE USE

Tobacco Use
□ Never used. □ Currently use. □ Quit (When did you quit?_____)
Type and amount per day:
Alcohol Use
□ Past. □ Present. □ Never
How often:
□ Occasional/Rare. □ Weekly. □ Daily
Estimated # of drinks per week:_____
Are you or others you know concerned about your alcohol use? □ Yes □ No
Have you ever received treatment for alcoholism or alcohol abuse? □ Yes □ No
If yes, please list the date(s) and location(s) of your treatment:
Recreational Drug Use (Includes prescription drug abuse)
□ Past □Present □ Never
Have you ever received treatment for drug abuse or addiction? □ Yes □ No
If yes, please list the date(s) and location(s) of your treatment:
Caffeine Use
□ Past. □ Present. □ Never
Estimated number of 8-oz. cups of caffeinated beverages per day: _____

LEGAL HISTORY

Do you have any legal history (prior court cases, arrests, etc.)? If yes, please describe:

Is this case involved in litigation, or do you intend to pursue litigation in the future? □ Yes □ No
Have you granted anyone Power of Attorney (POA)? □ Yes □ No
If so, who?_____

Thank you for completing this form. It is of great benefit to have this information prior to the initial session. Please email completed forms to:
admin@NeatCenterAustin.com, or
DrJenniferReynolds@NeatCenterAustin.com
(Send forms no less than 24 hours before your initial appointment)