

SERENITY NEUROPSYCHOLOGY, PLLC

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******PLEASE be complete. This form will help provide a thorough history necessary for treatment.**

Please **circle YES or NO or MARK the blank** as relevant. Otherwise, please answer the questions asked.

Patient Name: _____ DOB: _____ AGE: _____

Name/relationship of person completing form IF not the patient _____

If you have a nickname you prefer, please let us know _____

What are your treatment goals? _____

Describe any significant stressors you have experienced during the **PAST 1-3 YEARS**

Developmental/Childhood History

What is your primary language? _____ What hand do you write with? _____

Yes No Were you adopted?

If yes, how old were you when you were adopted? _____

Yes No Were you born prematurely?

If yes, how many weeks premature? _____

Yes No To your knowledge, were there any complications during your mother's pregnancy with you **or** during your birth?

If yes, what were the complications? _____

Yes No To your knowledge, did you meet developmental milestones on time (walking, talking, etc.)?

Yes No If you are comfortable answering, did you experience any type of abuse as a child?

If yes, what type of abuse _____

Yes No Did your parents divorce during your childhood?

If yes, how old were you when they divorced? age _____

How many siblings: _____ biological bro _____ biological sis _____ half-bro _____ half-sis
_____ step-bro _____ step-sis _____ adopted bro _____ adopted sis

Where were you born? _____ Where raised? _____

Who lived in your home during your childhood? _____

Please describe any significant events (good or bad) in your childhood? _____

Sex at Birth _____ Your sexual orientation? _____ Check if Prefer Not to Answer _____

Health History

PLEASE MARK the blank if you have the following:

_____ Pain in your hand(s) _____ Neuropathy in your hand(s) _____ Injury to your hand(s)

_____ Carpal Tunnel Syndrome _____ Surgery on your hand(s) for any condition

If any of the above are marked, which hand(s) is/are impacted? _____ R _____ L _____ Both

Yes No Are you colorblind?

Yes No Do you use hearing aids? _____ R _____ L _____ Both

Yes No If no hearing aids, do you feel you need aids or are you having trouble hearing others speak?

Yes No Are you currently being subjected to any abuse, neglect, or abandonment?

Yes No In the past 2 weeks, have you felt sad, down, or depressed?

Yes No In the past 2 weeks, have you lost interest, enjoyment, or pleasure in activities or people?

_____/10 How would you rate your level of depression during the past 2 weeks from 0 (no depression) to 10 (representing suicidal thinking)?

Yes No Have you been feeling anxious about a number of situations for at least the past 6 months?

Yes No Do you find it hard to stop worrying about situations/things?

_____/10 How would you rate your level of anxiety during the past 2 weeks from 0 (no anxiety) to 10 (representing a panic attack)?

____ Hours of sleep on average/typical night? Do you have trouble with (check any that apply):

____ going to sleep ____ staying asleep ____ waking too early ____ daytime fatigue ____ snoring

Yes No Have you noticed any change in your personality/behaviors recently?

If yes, please describe _____

Yes No Has anyone told you that your personality/behaviors seem different, inappropriate, or unusual compared to how you once acted?

If yes, please describe _____

Yes No Have you ever been hospitalized for a psychiatric/mental health disorder?

If yes, length of time _____ When _____ Reason _____

Yes No Have you ever engaged in outpatient counseling for psychiatric/mental health reasons?

If yes, length of time _____ When _____ Reason _____

Yes No Are you currently in outpatient counseling? With Whom _____

Yes No If not in counseling, are you interested in doing outpatient counseling/individual therapy?

Yes No Do you see a neurologist? Provider or Clinic _____

Have you in the past or are you currently experiencing any of the following?

Yes No Current Thoughts of Killing Yourself Yes No Past Thoughts of Killing Yourself

Yes No Cutting Behaviors Yes No Past Suicidal Attempts

Yes No Seeing Things Other People Do Not See Yes No Thoughts of Harming Someone

Yes No Hearing Things Other People Do Not Hear Yes No Anger Management Problems

Yes No Strong Beliefs Other People Do Not Seem to Have

If you are experiencing suicidal thoughts, describe how you keep yourself safe? _____

Please MARK any of the following that you are experiencing:

____ Forgetting events that occurred in your childhood

____ Forgetting events that occurred in the last few days/weeks/or months

____ Forgetting events that occurred in the last 1 to 2 yrs

____ Forgetting appointment times and/or appointment details

____ Forgetting important dates (birthdays, anniversaries, etc.)

____ Forgetting why you went into a room (more than typical)

____ Problems finding the correct word

____ Problems understanding words

____ Reduced ability to do 2 things at once/Reduced Multitasking

____ Thinking slower than you once did/Slowed Processing

____ Increased driving accidents/Getting tickets/citations/near misses

____ Problems with time management

____ Recent falls (How many _____)

____ Poor balance

____ Dizziness

____ Increased confusion

____ Forgetting today's date

____ Misplacing or Losing objects

____ Forgetting names of objects

____ Forgetting conversations

____ Decreased focus/Attention

____ Reduced Problem-Solving

____ Lost driving in familiar areas

____ Leaving burner/stove on

Please MARK any of the following that you have had completed:

____ Brain MRI

____ Head CT

____ Brain PET

____ Other neurological tests

____ Sleep Study

____ Blood work/labs (within last 1-2 years)

Please carefully review the following conditions and **MARK** any conditions in which you have ever been formally diagnosed and/or in which you are receiving formal treatment.

****Please make a separate notation on the designated line below if you believe you have a condition, but you have never been formally diagnosed**.**

☐ Addison's Disease	☐ High Cholesterol
☐ ALS/Lou Gehrig's Disease	☐ HIV/AIDS
☐ Anemia	☐ Hoarding
☐ Aneurysm	☐ Hormonal Changes
☐ Anoxia	☐ Hydrocephalus
☐ Anxiety	☐ Hyperparathyroidism
☐ Arthritis (Type _____)	☐ Hyperthyroidism
☐ Asthma	☐ Hypothyroidism
☐ Attention-Deficit/Hyperactivity Disorder (ADHD)	☐ Incontinence
☐ Autism or Asperger's/Autism Spectrum Disorder	☐ Insomnia
☐ Auto Immune (Type _____)	☐ Kidney Disease (Stage _____)
☐ Bipolar	☐ Learning Disability
☐ Borderline Personality Disorder	☐ Long-COVID (Long-haul COVID)
☐ Brain Arteriovenous Malformation (AVM)	☐ Lupus
☐ Brain Tumors (Type _____)	☐ Lyme Disease or Chronic Lyme
☐ Carbon Monoxide Poisoning	☐ Meningitis
☐ Cerebral Palsy	☐ Metabolic Conditions
☐ Cerebral Vascular Accident (Stroke)	☐ Migraine Headaches
☐ Cerebral Vasculitis	☐ Mild Cognitive Impairment
☐ Chronic Fatigue Syndrome	☐ Multiple Sclerosis (Type _____)
☐ COPD	☐ Nonepileptic Seizures
☐ COVID-19	☐ Obesity
☐ Cushing's Disease	☐ Obsessive Compulsive Disorder
☐ Dementia (Type _____)	☐ Parkinson's disease
☐ Depression	☐ Post Traumatic Stress Disorder
☐ Diabetes Type 1	☐ REM Behavior Sleep Disorder
☐ Diabetes Type 2	☐ Restless Legs Syndrome
☐ Eating Disorder (Type _____)	☐ Schizophrenia
☐ Electrical Shock Injury	☐ Sjogren's
☐ Encephalitis	☐ Substance Abuse (Type _____)
☐ Epilepsy/Seizures (Type _____)	☐ Tension Headaches
☐ Fibromyalgia	☐ Toxic Exposure (Type _____)
☐ Gum Disease	☐ Transient Ischemic Attack/TIA
☐ Hashimoto's	☐ Tremors (Type _____)
☐ Head Injury or Concussion	☐ Urinary Infections/UTIs (Frequent)
☐ Heart Attack	☐ Vit B12 deficiency
☐ Hepatitis C	☐ Vit D deficiency
☐ High Blood Pressure/Hypertension	☐ Whiplash
☐ Cancer (Type _____)	
Did you have: ☐ Chemotherapy ☐ Radiation ☐ Other Treatment	
☐ Chronic Pain Please rate your <u>typical</u> pain from 0-10 with 10 representing worst imaginable pain _____	
☐ Sleep Apnea (Do you regularly use: ☐ CPAP ☐ BIPAP ☐ Oral Device ☐ Inspire	

Other Conditions Formally Diagnosed:

****Conditions in which you feel you experience but are not diagnosed** _____

MARK if you have had surgery for your: ☐ brain ☐ heart ☐ neck ☐ back

☐ Total times in life in which you have been under general anesthesia

Please list all medications, including prescribed, supplements, and over-the-counter

MARK HERE _____ if you are attaching a list instead of listing them below:

Type of Medication/Supplement	Dosage/Frequency	Purpose
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		

Other medications/supplements _____

Date you most recently saw your prescribing provider for **PSYCHIATRIC MEDICATION**? _____

Who do you see for **PSYCHIATRIC MEDICATION** management? _____

Please list all allergies to medications or indicate none (may attach a list) _____

Substance Abuse History

Yes	No	Do you CURRENTLY drink alcohol?
		If yes...How often? _____
		How much do you drink in one sitting? _____
		How long have you been drinking? _____
		Type of alcohol? _____
Yes	No	Have you ABUSED alcohol in the past OR have you OR someone else ever been concerned about your drinking?
		If yes, when did you stop abusing alcohol (your age or what year)? _____
Yes	No	Do you CURRENTLY use recreational drugs?
		If yes... How often do you use drugs? _____
		What types of drugs do you use? _____
		How long have you been using drugs? _____
		When was your last use and what drug did you use? _____
Yes	No	Have you used recreational drugs in the past?
		If yes... What drugs have you used? _____
		When did you stop using (your age or what year)? _____
Yes	No	Have you attended chemical dependency treatment for alcohol and/or drug use?
		If yes, when? _____ How long was treatment? _____
Yes	No	Do you CURRENTLY use nicotine?
		If yes, how long have you used nicotine? _____ How much do you use? _____
Yes	No	Have you used nicotine in the past?
		If yes, how long did you use? _____ How much did you use? _____
		Type of nicotine? _____ When did you quit (your age or what year)? _____
Yes	No	Do you currently OR have you in the past vaped substances? Type _____

Legal History

Yes No Have you ever been convicted of any crimes other than minor traffic violations?
If yes, please explain _____

Yes No Are you **currently** involved in any legal issues (someone is suing you, you are suing someone, you anticipate upcoming legal involvement)
If yes, please explain _____

Educational History (Mark highest level of education as follows)

____ Less than High School ____ High School ____ Some college ____ AA ____ BS/BA
____ MS/MA ____ Doctorate If Less than High School, mark if you earned a GED? _____

If you attended college, what was your major(s)? _____

If you attended graduate/medical/law school, what was your emphasis/major? _____

What grades did you make in:

Elementary School:	A	B	C	D	F	
High School:	A	B	C	D	F	Final GPA _____
College/Undergrad:	A	B	C	D	F	Final GPA _____
Graduate/Medical/Law School:	A	B	C	D	F	Final GPA _____

Yes No Have you ever been diagnosed with a learning disability?
If yes, what type(s)? _____

Yes No Did you receive accommodations/special education in school?

Yes No Did you need to repeat a grade(s)?
If yes, what grade or grades? _____ Reason for repeat? _____

Yes No Behavioral problems in school (Principal's office, skipped school, expelled, suspended)?

What was your favorite subject(s) in school? _____

What was your least favorite subject(s) in school? _____

What was the name of your College/Undergraduate School? _____

What was the name of your Graduate/Medical/Law School? _____

Occupational History

Yes No Are you currently working?
If yes, how long have you been working at your current position? _____
If no, what is the reason you are not working? ____ Retired ____ Disability ____ Other
What is/was your occupation? _____
Types of previous jobs _____
Longest amount of time you held a job and what was your position? _____

Yes No Do you have a volunteer position?
If yes, how long have you been volunteering? _____
Where? _____
If yes, what are your duties/position? _____

Yes No NA Are you having any problems at your job or volunteer positions (please describe) _____

Military History

Yes No Have you ever served in the military?
What branch? _____

Yes No Did you see active combat?
How long did you serve? _____ Number of tours? _____

What are/were your duties/position/rank? _____

Psychosocial History

In what city do you live? _____ With whom do you live? _____

If relevant, Spouse's/Partner's Name _____ Spouse's Occupation _____

How long have you been with your spouse/partner? _____

Any children? Their names and ages? _____

Any pets? Types and their names? _____

How often do you exercise? ___ Never/Rarely ___ 1-2x per week ___ 3-4x per week ___ 5-7x per week

Type of exercise? _____

Activities/hobbies? _____

Level of social support? ___ Poor ___ Fair ___ Average ___ Above Average

Who do you look toward for social support? _____

Religious preference if any? _____ Check if Prefer Not to Answer ___

What are your strengths? _____

What are your weaknesses? _____

Yes No Do you have power of attorney papers completed?

Yes No Do you have a living will or advanced directives completed?

PLEASE MARK any of the following that you are having difficulties doing without assistance:

___ Personal Hygiene (Grooming, Shaving, Makeup, Dental Care, Etc.)

___ Bathing ___ Dressing ___ Eating/Swallowing ___ Moving/Transferring

___ Toileting ___ Walking ___ Shopping ___ Finance Management

___ Driving ___ Socializing ___ Communicating ___ Medication Management

___ Household Chores ___ Yardwork ___ Preparing Meals/Cooking

Family History (include only your BIOLOGICAL parents, siblings, children, grandparents, aunts/uncles)Their Relationship to You

___ 1) Depression 1) _____

___ 2) Bipolar 2) _____

___ 3) Anxiety 3) _____

___ 4) Alcohol Abuse 4) _____

___ 5) Drug Abuse 5) _____

___ 6) ADD/ADHD 6) _____

___ 7) Dementia (Type _____) 7) _____

___ 8) Mild Cognitive Impairment 8) _____

___ 9) Multiple Sclerosis (MS) 9) _____

___ 10) Parkinson's disease 10) _____

___ 11) Stroke/TIA's (transient ischemic attack) 11) _____

___ 12) Epilepsy/Seizure Disorder 12) _____

___ 13) ALS/Lou Gehrig's disease 13) _____

___ 14) Autoimmune (Type _____) 14) _____

___ 15) Other _____ 15) _____

Yes No Was anyone in your **biological** family deceased before age 65 _____

Yes No Is your father living? Age of death? _____ Cause of death _____

Yes No Is your mother living? Age of death? _____ Cause of death _____

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