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, answer the questions asked.

Patient Name:_____ DOB:_____ AGE:_____

Name of person completing this form IF other than the patient_____
Relationship to 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 1-2 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 To your knowledge, did you meet developmental milestones on time (walking,talking, etc.)?
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 If you are comfortable answering, did you experience any type of abuse as a child?
If yes, what type of abuse_____
Yes No Are your parents divorced?
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?_____

_____

What is your sexual orientation?_____ **OR** 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:
_____ 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?
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 **or** weeks
_____ Forgetting events that occurred in the last few months **or** 1-2 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/warnings
_____ Problems with time management
_____ Poor balance
_____ Recent falls (How many____)
_____ 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 <u>have ever been formally diagnosed and/or in which you are receiving formal treatment</u>.**
****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
_____ ALS/Lou Gehrig's Disease
_____ Anemia
_____ Aneurysm
_____ Anoxia
_____ Anxiety
_____ Arthritis (Type_____)
_____ Asthma
_____ Attention-Deficit/Hyperactivity Disorder (ADHD)
_____ Autism or Asperger's/Autism Spectrum Disorder
_____ Auto Immune (Type_____)
_____ Bipolar
_____ Borderline Personality Disorder
_____ Brain Arteriovenous Malformation (AVM)
_____ Brain Tumors (Type_____)
_____ Carbon Monoxide Poisoning
_____ Cerebral Palsy
_____ Cerebral Vascular Accident (Stroke)
_____ Cerebral Vasculitis
_____ Chronic Fatigue Syndrome
_____ COPD
_____ COVID-19
_____ Cushing's Disease
_____ Dementia (Type_____)
_____ Depression
_____ Diabetes Type 1
_____ Diabetes Type 2
_____ Eating Disorder (Type_____)
_____ Electrical Shock Injury
_____ Encephalitis
_____ Epilepsy/Seizures (Type_____)
_____ Fibromyalgia
_____ Gum Disease
_____ Hashimoto's
_____ Head Injury or Concussion
_____ Heart Attack
_____ Hepatitis C
_____ High Blood Pressure/Hypertension
_____ High Cholesterol
_____ HIV/AIDS
_____ Hoarding
_____ Hormonal Changes
_____ Hydrocephalus
_____ Hyperparathyroidism
_____ Hyperthyroidism
_____ Hypothyroidism
_____ Incontinence
_____ Insomnia
_____ Kidney Disease (Stage_____)
_____ Learning Disability
_____ Long-COVID (Long-haul COVID)
_____ Lupus
_____ Lyme Disease or Chronic Lyme
_____ Meningitis
_____ Metabolic Conditions
_____ Migraine Headaches
_____ Mild Cognitive Impairment
_____ Multiple Sclerosis (Type_____)
_____ Nonepileptic Seizures
_____ Obesity
_____ Obsessive Compulsive Disorder
_____ Parkinson's disease
_____ Post Traumatic Stress Disorder
_____ REM Behavior Sleep Disorder
_____ Restless Legs Syndrome
_____ Schizophrenia
_____ Sjogren's
_____ Substance Abuse (Type_____)
_____ Tension Headaches
_____ Toxic Exposure (Type_____)
_____ Transient Ischemic Attack/TIA
_____ Tremors (Type_____)
_____ Urinary Infections/UTIs (Frequent)
_____ Vit B12 deficiency
_____ Vit D deficiency
_____ 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 <u>Formally Diagnosed</u>:_____

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

MARK if you have had <u>surgery</u> for your: _____brain _____heart _____neck _____back

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 ONLY**?_____

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

Please list all allergies to medications (or 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 (age/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 (age/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?_____
What type of nicotine did you use?_____ When did you quit (age/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 problems)
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 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?_____ Times you have you been married?_____

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?_____

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 <u>having difficulties doing without assistance</u>:

___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 <u>only your BIOLOGICAL</u> children, parents, siblings, grandparents, aunts/uncles**)

	<u>Their Relationship to You</u>
_____ 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_____