UTHealth The University of Texas Health Science Center at Houston | McGovern Medical School

NEUROPSYCHOLOGY HISTORY FORM

Please fill out this form to the best of your knowledge. If some questions are not applicable to you, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet. Completing this form thoroughly will reduce interview time.

Form completed by: _____Relationship to patient (if applicable): _____

Date form completed: _____

General Information

Patient's Name: _____Gender: _____
First Middle Last

Date of Birth: _____ Age: _____ Ethnic/Cultural Background (optional) _____

Patient's Address:

_____
Number and Street City State Zip

Home phone: _____ Cell phone: _____ Work phone: _____

Occupation: _____ Retired: ☐ No ☐ Yes If yes, what date/year? _____

Primary Insurance_____ Policy/ID Number _____

Primary language spoken in the home: _____ Other language(s) spoken in the home:_____

Marital Status: ☐ Single ☐ Married (# yrs) ____ ☐ Committed relationship ☐ Widowed ☐ Separated ☐ Divorced

Number and ages of children: _____

Are children living with the patient? ☐ Yes ☐ No How many?_____

Patient lives: ☐ With spouse or partner/family ☐ Alone with assistance ☐ Alone with no assistance
☐ Senior living community ☐ Assisted Living ☐ Nursing Home ☐ Other:_____

Emergency Contact Name: _____ Phone _____

Referral Information

Who referred you for a Neuropsychological evaluation? _____

Address of referral source:_____

Phone number of referral source: _____ **Fax number of referral source:** _____

Have you had a prior Neuropsychological Evaluation? ☐ **Yes** ☐ **No**

A copy of your report will be sent to the referral source and a copy will be placed in your electronic medical record. If you desire other persons to receive the report, Please request a release of information form.

Educational History

Highest grade completed? ☐ **Less than High School (Last grade completed_____)** **GED** ☐ **Yes** ☐ **No**

☐ **High School** ☐ **Some college** ☐ **Associate's** ☐ **Bachelor's** ☐ **Graduate Degree (Specify:_____)**

Identified learning disabilities (e.g. dyslexia, intellectual disability) or ADHD/ADD during school years?

☐ **Yes** ☐ **No If yes, please describe:**_____

Special education? ☐ **Yes** ☐ **No If yes, for what reason?**_____

Any concern about possible difficulties that were not identified? ☐ **Yes** ☐ **No If yes,**

describe:_____

Was the patient ever held back in school? ☐ **Yes** ☐ **No What grade/s?**_____

Why?_____

Current Concerns

Please describe the reason you/the patient was referred to our office:_____

_____

Please mark any of the following difficulties you/patient experience/s on a day-to-day basis:

*** Please note how long ago symptoms started (6 months, 1 year, 2 years, etc.) on the line provided after symptom(s)**

☐ Forgetting things that happened recently _____

☐ Forgetting appointments _____

☐ Forgetting names of ___friends ___ family _____

☐ Forgetting recent conversations _____

- [ ] Losing things more frequently _____
- [ ] Asking the same question(s) over and over _____
- [ ] Trouble remembering: the date _____ day of week _____month_____year_____
- [ ] Trouble remembering to take medications _____
- [ ] Forgetting daily routine (teeth, shaving, bathing, etc) _____
- [ ] Difficulty learning new things (cell phone, etc) _____
- [ ] Forgetting how to operate something that you knew in the past (remote, stove, washer, tools, computer, phone, etc) _____
- [ ] Mixed up/lost while driving or riding in car _____
- [ ] Confused in familiar places_____
- [ ] Harder to express thoughts or ideas to others _____
- [ ] Difficulty speaking/talking (slurring of words, mumbling) _____
- [ ] The "wrong" words come out _____
- [ ] Can't quite "grab" the correct word _____
- [ ] Trouble recalling names of things _____
- [ ] Meaning of words is vanishing _____
- [ ] Can't follow conversations as easily _____
- [ ] Need statements simplified due to poor comprehension_____
- [ ] Harder to follow a TV program/movie or book _____
- [ ] Difficulty concentrating or paying attention _____
- [ ] Harder to think through problems/make decisions _____
- [ ] Planning is harder (family meal, trip, projects) _____
- [ ] Harder to stay organized _____
- [ ] Harder deciding what is most important _____
- [ ] Making uncharacteristically poor decisions _____
- [ ] Writing difficulty (change over time) _____
- [ ] Difficulty spelling _____
- [ ] Not seeing things correctly/vision problems _____
- [ ] Reading difficulty (slowed, or ceased reading) _____
- [ ] Math difficulty (balancing checkbook, etc) _____

Problems in the following areas and duration: * Please check ALL of the problems observed

- ☐ Hygiene changes (difficulty bathing, styling hair, shaving, wearing clean clothing) _____
- ☐ Dressing (clothing choices or putting clothes on) _____
- ☐ Can't bathe/shower independently _____
- ☐ Can't use the bathroom independently _____
- ☐ Less safety awareness _____
- ☐ Cooking (leaving stove on, forgetting ingredients/recipes, etc.) _____
- ☐ Paying bills_____
- ☐ Managing money/Investments_____
- ☐ Performing household/yard chores _____
- ☐ Fender benders or accidents: _____How many _____How many months/years_____
- ☐ Grocery shopping _____
- ☐ Decreased driving (night, highways etc) _____
- ☐ No longer driving
- ☐ Emotional changes (irritable, sad, up and down, etc.) _____
- ☐ Saying or doing things that are uncharacteristic _____
- ☐ Sitting around more often/no motivation _____
- ☐ Personality changes (less patient, nicer, nastier, friendlier, eating more sweets, aloof, messy, not motivated) _____
- ☐ Decreased involvement in hobbies _____
- ☐ Not as outgoing or social _____
- ☐ Decline in social skills (rude, inappropriate, quiet, etc.) _____
- ☐ More likely to talk to strangers _____
- ☐ Compulsive behavior (spending, pornography, internet, Food, hobbies, gambling, etc.) _____
- ☐ Hoarding/buying unnecessary things _____

What year did you/the patient first notice problems? _____
What was your earliest symptom/change that concerned you?_____

What are you hoping to achieve with this evaluation?_____

Will any procedures conducted at our offices be part of an ongoing or planned legal case or disability case, and if so, please describe:

_____

_____

_____

_____

Services/Interventions Sought Previously for this Problem

☐ Medical lab Evaluation ☐ Neuropsychological Assessment ☐ Psychiatrist ☐ Neurological Exam

☐ Medication ☐ Counseling or Therapy ☐ Speech Therapy

Has the patient had any of the following forms of psychological treatment? If so, how long did it last?

Individual psychotherapy? ☐ Yes ☐ No Duration and date of therapy? _____

Inpatient mental health treatment? ☐ Yes ☐ No Duration and date of placement? _____

Suicide Attempts? ☐ Yes ☐ No How many_____
When?_____
Method_____

Are you/the patient currently receiving psychological treatment? If so, with whom and how often?

_____

Are you/the patient under the care of a psychiatrist? If so, with whom and how often?

_____

Significant Stressors

Have there been any major changes within the family life or the patient's living situation that have affected the patient's functioning (e.g., deaths, moves, divorces, loss of job, etc)? ☐ No ☐ Yes (describe below)

_____

_____

_____

Medical/Health History

Patient's primary physician_____Phone Number_____

Vision problem? ☐ Yes ☐ No Hearing problem? ☐ Yes ☐ No

Decreased sense of smell/taste? ☐ Yes ☐ No

☐ Difficulty swallowing ☐ Drooling ☐ Gagging ☐ Choking ☐ Difficulty Walking ☐ Dropping things?

Appetite concerns? Normal Decreased Increased Weight loss (lbs)_____ Weight gain (lbs)_____

Balance problems? ☐ Yes ☐ No How many falls:_____ In past: days ____weeks_____ year(s)_____

Weakness? ☐ Yes ☐ No Where?_____

Tremors/Shaking? ☐ Yes ☐ No Body Part:_____ How Long?_____

Hearing or seeing things that are not there? ☐ Yes ☐ No How long?_____How often?_____

Details:_____

_____

Does the patient have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No

Waking up during the night? ☐ Yes ☐ No If Yes, how many times per night typically?_____

Concerns related to toileting accidents or bowel/bladder incontinence or leaking ☐ Yes ☐ No

If yes, please describe: _____

MEDICATION HISTORY: (Use back of form or attach a sheet that includes medications)

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

MEDICAL HISTORY: (Use back of form if necessary or attach a list of medical problems)

Medical Problem	Date of Diagnosis	Description of problem. Please write on the back of this form if necessary

Surgeries: Age: _____ Reason: _____Where: _____

_____

Surgeries: Age: _____ Reason: _____Where:_____

Hospitalizations: Age: _____ Reason: _____Where:_____

_____

Details:_____

Major accidents or injuries: Age: _____ Type (head, abdomen, fracture, etc.) _____

Details_____

Major accidents or injuries: Age: _____ Type (head, abdomen, fracture, etc.) _____

Details:_____

Has the patient ever been knocked unconscious? ☐ Yes ☐ No If yes, details and how long:_____ _____

_____

Has the patient ever been exposed to any toxic chemicals? ☐ Yes ☐ No If yes, please explain: _____

_____

Has the patient had any of the following tests or evaluations?

	Yes	Date (month/ year)	Where	Results
Neurological Evaluation				**Normal Abnormal Don't Know**
CT scan of head				**Normal Abnormal Don't Know**
MRI scan of head				**Normal Abnormal Don't Know**
EEG				**Normal Abnormal Don't Know**
Audiology or hearing evaluation				**Normal Abnormal Don't Know**
Vision evaluation				**Normal Abnormal Don't Know**
Genetic Testing				**Normal Abnormal Don't Know**
Other laboratory tests				**Normal Abnormal Don't Know**

Substance Use

How many alcoholic drinks a day/week does the patient consume and what kind? _____

_____

At what age did patient start drinking? _____ When was the patient's last drink of alcohol? _____

Has the patient ever experienced problems due to alcohol consumption, and if so, please describe: _____

_____

Is there a family problem of alcohol abuse, and if so, please describe: _____

_____

Has the patient ever used any of the following?

Marijuana Heroin Cocaine/Crack LSD Ecstasy Methamphetamines Hallucinogens

Other non-prescribed drugs, please describe: _____

If the patient has used any of the above, please indicate frequency of use, age of first use, and describe any treatment:_____

_____

_____

Has the patient received any treatment for alcohol or other substance use? ☐ Yes ☐ No If yes, please describe:_____

_____

_____

Does the patient smoke cigarettes, pipes, cigars, or chew tobacco? ☐ Yes ☐ No

If yes, please describe frequency and amount:_____

Family Medical History

Have any of the patient's family members had the following problems/disorders? Please specify the family member's relationship to the patient and whether the relationship is on the maternal (m) or paternal (p) side. Example: aunt (p) = aunt on the father's side.

	Family Member(s) Relation to Patient		Family Member(s) Relation to Patient
Stroke/Aneurysm		Alcohol/ Drug abuse	
Anxiety		Attention Deficit Disorder	
Autism/ Asperger's		Bipolar disorder	
Birth defect		Cancer	
Dementia		Memory Problems	
Depression		Diabetes	
Genetic disorder		Heart Disease	
Parkinson's Disease		Mental retardation	
Migraine headaches		Multiple sclerosis	
Essential Tremor		Obsessive-Compulsive Disorder	
Schizophrenia		Seizures or epilepsy	
Academic Problems		Tics/ Tourette's Disorder	

Other (specify): _____

Personal/Social Information

What are the patient's main hobbies and interests?

How often is the patient participating in these activities?

Has there been a decline in the patient's ability to do things that were once simple/easy? (home repairs, cooking, sewing, auto maintenance, etc)

Legal

Has the patient had any involvement with the legal system? ☐ **Yes** ☐ **No**

Is the patient currently on parole? ☐ **Yes** ☐ **No** **Is the patient currently on probation?** ☐ **Yes** ☐ **No**

Is there a lawsuit in relation to the problems for which you are being assessed? ☐ **Yes** ☐ **No**

Do you currently have a lawyer who you are discussing possible litigation with? ☐ **Yes** ☐ **No**
If yes, describe:

Are you currently involved in a Worker's Compensation case? ☐ **Yes** ☐ **No**

Previous Worker's Compensation history? ☐ **Yes** ☐ **No** **If yes to either question, provide details:**

_____

_____

_____

Is the patient currently receiving disability? ☐ **Yes** ☐ **No** **If yes, specify condition:**

_____

Is the patient currently applying for disability? ☐ **Yes** ☐ **No** **If yes, specify condition:**

_____

Occupational History

Present or Most Recent Job (Include job titles, description of work, years employed):

_____

_____

_____

Previous Jobs (job titles, description of work, years employed, and reason for change):

_____

_____

_____

_____

_____

Any problems encountered in your current work activities?

_____

_____

_____

Other Concerns

Please use this space to write in any additional concerns that were not addressed in this questionnaire.

_____
_____
_____
_____
_____

The information I have provided is true and correct to the best of my knowledge:

_____ _____

Patient Signature (or POA) **Date**