



Adult Neuropsychological History

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Thank you for filling out this questionnaire before the consultation. This will help us provide the best care for you. A brief description of the evaluation and map can be found at <http://www.medicalneuropsych.com>

Patient Name _____ **Date** _____

Address _____

Phone (H) _____ (W) _____

Age _____ **Birth Date** _____ **Gender** M F

Handedness (Writing) R L

Primary Language _____ **Secondary Language** _____

Ethnic or Racial Background _____

Occupation _____

Medical Diagnosis (if any) 1) _____

2) _____

Date of Diagnosis _____

Referred by _____

Form Completed by _____

Relationship _____

Phone (H) _____

Phone (W) _____

BIRTH AND DEVELOPMENTAL HISTORY

You were born: On time ____ Prematurely ____ Late ____

Your weight at birth: ____ lbs. ____ oz.

Mother's weight gain during pregnancy: ____ lbs.

Were there any complications associated with your birth (e.g. oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g., need for oxygen, special equipment used, convulsions, illness, etc.)?

Yes ____ No ____

If yes, please describe: _____

Check all that applied to your mother while she was pregnant with you:

____ Accident

____ Alcohol use

____ Cigarette smoking

____ Drug use (marijuana, amphetamine, cocaine, LSD etc.)

____ Illness (toxemia, diabetes, high blood pressure, Rh incompatibility, etc.)

____ Poor nutrition

____ Psychological problems

____ Other problems: _____

List all medications (prescribed or over-the-counter) your mother took while pregnant:

During her pregnancy, did your mother live near a polluted area (e.g. toxic waste dump) or other hazardous area (e.g. nuclear plant, industrial area, pesticide sprayed area, etc.)?

Yes ____ No ____

If yes, please describe: _____

To your knowledge, when did you develop the following skills:

| | Early | Average | Late |
|---------------------|-------|---------|------|
| Walking | ___ | ___ | ___ |
| Language | ___ | ___ | ___ |
| Toilet Training | ___ | ___ | ___ |
| Overall development | ___ | ___ | ___ |

As a child, did you have any of these problems? (Check all that apply.)

- | | | |
|-----------------------------|-------------------------|----------------------------------|
| ___ Attention problems | ___ Head injury | ___ Muscle tightness or weakness |
| ___ Clumsiness | ___ Hearing problems | ___ Speech problems |
| ___ Developmental delay | ___ Hyperactivity | ___ Vision problems |
| ___ Frequent ear infections | ___ Learning disability | |
| ___ Other problems: _____ | | |

MEDICAL HISTORY

Childhood Medical History

Check all of the conditions you experienced as a child. Please add details (e.g. age of onset, treatment, etc.):

- | | | |
|---|--------------------------------|----------------------|
| ___ Allergies | ___ Epilepsy or seizures | ___ Pneumonia |
| ___ Asthma | ___ Fevers (104° F or higher) | ___ Poisoning |
| ___ Brain infection or disease | ___ Heart problems | ___ Polio |
| ___ Cancer | ___ Immune system disease | ___ Rheumatic fever |
| ___ Cerebral palsy | ___ Kidney problems | ___ Scarlet fever |
| ___ Chicken pox | ___ Lung (respiratory) disease | ___ Tuberculosis |
| ___ Colds (excessive) | ___ Measles | ___ Venereal disease |
| ___ Diabetes | ___ Meningitis | ___ Whooping cough |
| ___ Encephalitis | ___ Oxygen deprivation | |
| ___ Other diseases or disabilities: _____ | | |
-

As a child, were you exposed to excessive amounts of lead (e.g. eating paint chips, living next to high concentrations of automotive exhaust fumes, etc.)?

Yes ____ No ____

If yes, please describe: _____

As a child, did you have an accident, which required a hospital visit?

Yes ____ No ____

If yes, please describe: _____

Did you ever suffer a serious injury to your head?

Yes ____ No ____

If yes, explain the circumstances and any problems you had afterwards: _____

How would you describe your nutrition as a child and adolescent?

Excellent ____ Average ____ Poor ____

List the medications that were regularly given to you as a child:

| Medication | Reason For Medication |
|------------|-----------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Adult Medical History

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hazardous substance exposure | <input type="checkbox"/> Oxygen deprivation |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Arteriosclerosis (artery disease) | <input type="checkbox"/> Huntington's Disease | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Brain infection or disease | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Radiation exposure |
| <input type="checkbox"/> Cancer or chemotherapy | <input type="checkbox"/> Lung (respiratory) disease | <input type="checkbox"/> Senility (Dementia) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Stroke or TIA) |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Other diseases or disabilities: | _____ | |
-

As an adult, did you have an accident, which required a hospital visit?

Yes No

If yes, please describe: _____

Did you ever suffer a serious injury to your head?

Yes No

If yes, explain the circumstances and any problems you had afterwards: _____

List any prescription or over-the-counter medications you are currently taking and the dosages:

| | Name | Dosage | Reason |
|----|-------|--------|--------|
| a) | _____ | _____ | _____ |
| b) | _____ | _____ | _____ |
| c) | _____ | _____ | _____ |
| d) | _____ | _____ | _____ |
| e) | _____ | _____ | _____ |
| f) | _____ | _____ | _____ |

Do you have epilepsy or a seizure disorder? Yes No

If yes, check the one the appropriate type:

PARTIAL

- Simple partial (Jacksonian)
- Complex partial (Psychomotor)
- Partial evolving into generalized

GENERALIZED

- Absence (Petit mal)
- Myoclonic
- Clonic
- Tonic
- Tonic-clonic (Grand mal)
- Atonic

UNCLASSIFIED _____

I have a seizure disorder, but I don't know which type.

Have you had a prior psychological or neuropsychological evaluation? Yes No

Psychologist _____

Address _____

Date and reason for evaluation _____

Findings _____

Check all medical procedures that have been done:

| | Check if Normal | Date | Abnormal Findings |
|--|--------------------------|-------|-------------------|
| <input type="checkbox"/> Angiogram | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> Blood work | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> EEG | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> Lumbar Puncture or spinal Tap | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> MRI | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> Neurological Examination | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> PET Scan | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> SPECT | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> Physical Examination | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> Skull x-ray | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> Other Tests | <input type="checkbox"/> | _____ | _____ |

FAMILY HISTORY

Mother

What is your mother's name? (include maiden name) _____

Is she alive? Yes ____ No ____

If deceased, what was the cause of death? _____

Mother's occupation: _____

Mother's level of education: _____

Mother's hobbies: _____

Does your mother have a known or suspected learning disability? Yes ____ No ____

If yes, describe: _____

Briefly describe your mother's health history: _____

Father

What is your father's name? _____

Is he alive? Yes ____ No ____

If deceased, what was the cause of death? _____

Father's occupation: _____

Father's level of education: _____

Father's hobbies: _____

Does your father have a known or suspected learning disability? Yes ____ No ____

If yes, describe: _____

Briefly describe your father's health history: _____

When you were born, what was your mother's age? ____ Father's age ____

How many brothers and sisters do you have? ____

Where are you in the birth order? ____

Are there any unusual problems (physical, academic, psychological) associated with any of your brothers or sisters?

Yes ____ No ____

If yes, describe: _____

PERSONAL HISTORY

Marital History

Current marital status: Married _____ Single _____ Divorced _____
Widowed _____ Separated _____

Years married to current spouse: _____

Number of times married: _____

Spouse's name: _____ Spouse's age: _____

Spouse's occupation: _____

Spouse's health: Excellent _____ Good _____ Poor _____

Not married, but living with partner: Yes _____ No _____ His/her age: _____

His/her health: Excellent _____ Good _____ Poor _____

His/her occupation: _____

Children

| Name | Age | General Health and Behavior |
|------|-----|-----------------------------|
|------|-----|-----------------------------|

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Who currently resides with you? _____

EDUCATIONAL HISTORY

Highest grade or degree earned: _____ Field: _____

Grades achieved (with any additional comments):

_____ A & B _____

_____ B & C _____

_____ C & D _____

_____ D & F _____

Best subject _____ Worst subject _____

Did you ever repeat or skip a grade? Yes _____ No _____

Comments: _____

Did you ever receive special (remedial) classes or tutors? Yes _____ No _____

Comments: _____

OCCUPATIONAL HISTORY

Current occupation: _____

How long have you had this job? _____

Job responsibilities: _____

| | Prior Jobs | Responsibilities | Time on Job |
|----|------------|------------------|-------------|
| a) | _____ | _____ | _____ |
| b) | _____ | _____ | _____ |
| c) | _____ | _____ | _____ |

At any time on a job, were you exposed to toxic, hazardous, noxious, or otherwise dangerous or unusual substances (e.g., lead, mercury, radiation, solvents, pesticides, chemicals, etc)?

Yes _____ No _____

If yes, explain: _____

MILITARY HISTORY

Branch: _____

Discharge rank: _____ Type of Discharge: _____

Major duties: _____

Did you sustain any physical injuries in the military? Yes _____ No _____

If yes, describe: _____

Were you exposed to any dangerous or unusual substances during your service (e.g., Agent Orange, radiation, etc.)?

If yes, describe: _____

RECREATION & DAILY LIVING

What types of recreation do you enjoy: _____

Do you currently need help with daily activities (i.e. dressing, cooking, driving)?

Yes _____ No _____

Comments: _____

SUBSTANCE USE HISTORY

Alcohol

I started drinking regularly at age:

Less than 10 years old ____ 10-15 ____ 16-18 ____ 19-20 ____ 21 or over ____

I drink alcohol:

rarely or never ____ 1-2 days/week ____ 3-5 days/week ____ Daily ____

I used to drink but have I stopped on: (date) _____

Preferred type(s) of drinks: _____

Usual number of drinks I have at a time: _____

My last drink was: less than 24 hours ago ____ 24-48 hours ago ____ Over 48 hours ago ____

Check all that apply:

____ I can drink more than most people my age and size before I get drunk.

____ I sometimes get into trouble (fights, difficulty, problems at work, conflicts with family, accidents, etc.) after drinking.

____ I sometimes blackout after drinking.

____ I have had a seizure after drinking.

____ I have missed work or social engagements because of my drinking.

____ I have been arrested for DUI.

____ I have experienced the DT's after I stopped drinking.

____ I have been in treatment to quit drinking.

Please explain: _____

Tobacco

I started smoking regularly at age:

Less than 10 years old ____ 10-15 ____ 16-18 ____ 19-20 ____ 21 or over ____

How many cigarettes do you smoke daily? _____

Drugs

Please check all the drugs you are now using or have used in the past:

| | Presently Using | Used in past |
|---|--------------------------|--------------------------|
| <input type="checkbox"/> Amphetamines (including diet pills) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Barbiturates (downers etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Cocaine or crack | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hallucinogenics (LSD, acid, STP, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Inhalants (glue, paint, nitrous oxide, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Opiate narcotics (heroin, morphine, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> PCP (or "angel dust") | <input type="checkbox"/> | <input type="checkbox"/> |

Please list all other drugs: _____

Do you consider yourself dependent on any **above** drugs? Yes No

Which one(s)? _____

Do you consider yourself dependent on any **prescription** drugs? Yes No

Which one(s)? _____

Check all that apply:

I have gone through drug withdrawal.

I have used I.V. drugs.

I have been in drug treatment.

PSYCHOLOGICAL HISTORY

Have you been in therapy before with a psychiatrist, psychologist, social worker, marriage and family therapist or other mental health professional? Yes _____ No _____

Name and Location of Therapist

Dates

Have you received a neuropsychological evaluation before?

Yes _____ No _____

Name and Location of Neuropsychologist

Dates

LEGAL

Is the evaluation part of ongoing or pending litigation?

Yes _____ No _____

Have you spoken to an attorney about this evaluation?

Yes _____ No _____

Do you have ongoing or pending civil or criminal legal proceedings?

Yes _____ No _____

Name, location, and phone number of attorney:
