

**NEUROPSYCHOLOGY
ADULT HISTORY**

Person completing this form: Patient ___ Spouse ___ Parent ___ Other _____

Patient's Name: _____ Date: _____

Date of Birth: _____ Age: ___ Sex: ___ Race: ___ Marital Status: _____

Address: _____ SS#: _____

Phone #s: Home: _____ Work: _____ Cell: _____

Injured while working? (Workers' Comp) No ___ Yes ___ Date of Injury _____

Injured in accident? No ___ Yes ___ Cause _____ Date _____

Applying/Applied for Disability? No ___ Yes ___ Granted? ___ Denied? ___ Date _____

Are you represented by attorney? No ___ Yes ___ Attorney's Name _____

Briefly explain the main concern or problem that brings you to LSUHSC and why your doctor requested this evaluation. _____

Specific cognitive problems (attention or memory problems, etc.)? No ___ Yes ___ (please describe)

When did these problems begin? _____

Did they begin: Abruptly ___ Gradually ___

Have they gotten: Better ___ Worse ___ Stayed the Same ___

Have you or others noticed changes in your:

Memory? No ___ Yes ___ (explain) _____

Speech? No ___ Yes ___ (explain) _____

Appearance? No ___ Yes ___ (explain) _____

Mood or personality? No ___ Yes ___ (explain) _____

Movements or motor functioning? No ___ Yes ___ (explain) _____

Medical History:

Do you know if your mother had any difficulty during her pregnancy with you?

No ____ Unknown ____ Yes ____ (explain) _____

Were you born prematurely or were there any complications at the time of your birth?

No ____ Unknown ____ Yes ____ (explain) _____

Were there any problems with your development during childhood?

No ____ Unknown ____ Yes ____ (explain) _____

Please list any medical illnesses:

Age

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any operations/hospitalizations:

Age

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had?

- Brain Surgery No ____ Yes ____ Age ____ Type/Location, if known: _____
- Meningitis No ____ Yes ____ Age ____
- Encephalitis No ____ Yes ____ Age ____
- Cancer No ____ Yes ____ Age ____ Type/Location, if known: _____
- High blood pressure No ____ Yes ____ Age ____
- Low blood pressure No ____ Yes ____ Age ____
- Heart Disease No ____ Yes ____ Age ____
- Heart Attack No ____ Yes ____ Age ____
- Diabetes No ____ Yes ____ Age ____ Type, if known: _____
- Multiple Sclerosis No ____ Yes ____ Age ____ Type, if known: _____
- Parkinson's Disease No ____ Yes ____ Age ____

Have you ever had?

- A fever of 104 or above? No ___ Yes ___ Age ___ (Explain: _____)
- Loss of consciousness / Coma No ___ Yes ___ Age ___ (Explain: _____)
- Head Injury No ___ Yes ___ Age ___ (Describe in section below)
- Seizures No ___ Yes ___ Age ___ (Describe in section below)
- CPR/artificial respiration? No ___ Yes ___ Age ___
- Fibromyalgia No ___ Yes ___ Age ___
- Chronic Fatigue No ___ Yes ___ Age ___
- Lupus No ___ Yes ___ Age ___
- Chronic Pain No ___ Yes ___ Age ___
- Sleep Apnea No ___ Yes ___ Age ___
- Lyme's Disease No ___ Yes ___ Age ___
- Rocky Mountain Spotted Fever No ___ Yes ___ Age ___
- Arthritis No ___ Yes ___ Age ___ (Explain: _____)
- Emphysema No ___ Yes ___ Age ___
- Anemia No ___ Yes ___ Age ___
- Lead or Other Poisoning No ___ Yes ___ Age ___ (Explain: _____)
- Migraine Headaches No ___ Yes ___ Age ___
- Tension Headaches No ___ Yes ___ Age ___
- Vision Problems No ___ Yes ___ Age ___
Do your glasses correct your visual difficulties? No ___ Yes ___ Not applicable ___
- Cataract surgery No ___ Yes ___ Age ___ Both ___ Left ___ Right ___
- Hearing problems No ___ Yes ___ Age ___
- Tremors/Shakiness No ___ Yes ___ Age ___
- Dizziness No ___ Yes ___ Age ___
- Frequent falling No ___ Yes ___ Age ___ (Explain: _____)
- Sleep problems No ___ Yes ___ Age ___
- Allergies No ___ Yes ___ Age ___
- Asthma No ___ Yes ___ Age ___
- Injured arms/hands/fingers No ___ Yes ___ Age ___
- Other: _____

If you ever had a head injury (i.e., concussion, brain injury, etc.), complete below:

Age at the time of the **first** head injury: _____ Do you remember the actual event? No ___ Yes ___

Describe the head injury: _____

Did you lose consciousness? No ___ Yes ___ Length of unconsciousness: _____

What was your last clear memory before the injury? _____

What was your first clear memory after the injury? _____

Describe any medical treatment/medication you received in relation to the head injury: _____

List any physical symptoms you had following the head injury (such as vomiting, blurred vision, or headache): _____

How long did it take for you to get back to your "old self" after the head injury? _____

If you have had more than one head injury, please complete this section:

Age at the time of the **second** head injury: _____ Do you remember the actual event? No ___ Yes ___

Describe the head injury: _____

Did you lose consciousness? No ___ Yes ___ Length of unconsciousness: _____

What was your last clear memory before the injury? _____

What was your first clear memory after the injury? _____

Describe any medical treatment/medication you received in relation to the head injury: _____

List any physical symptoms you had following the head injury (such as vomiting, blurred vision, or headache): _____

How long did it take for you to get back to your "old self" after the head injury? _____

If you have had recurrent seizures, please complete this section:

Age of first seizure: _____ When was your last seizure: _____

Describe the seizure: _____

Did you lose consciousness during the seizure? No ___ Partially ___ Completely ___

How long does it take for you to recover or return to normal after having a seizure? _____

How often do the seizures occur (number per day, week, or month)? _____

What medications do you currently take for seizures? _____

Have you ever had?

EEG	No ___	Yes ___	Date or Age _____	Results _____
CT scan	No ___	Yes ___	Date or Age _____	Results _____
MRI scan	No ___	Yes ___	Date or Age _____	Results _____
PET scan	No ___	Yes ___	Date or Age _____	Results _____
SPECT scan	No ___	Yes ___	Date or Age _____	Results _____
Spinal Tap	No ___	Yes ___	Date or Age _____	Results _____
Psychological Testing	No ___	Yes ___	Date or Age _____	By Whom _____
Neuropsychological Testing	No ___	Yes ___	Date or Age _____	By Whom _____

Current medication(s) and reason for taking:

Dosage (if known)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications used in the past for more than 3 continuous months:

Dosage (if known)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Caffeine Use

Do you drink caffeinated beverages on a daily basis (e.g., coffee, tea, pop)? No ___ Yes ___

If yes, specify the type and amount per day: _____

Tobacco Use

Do you currently use tobacco? No ___ Yes ___

If yes, specify the type and quantity per day: _____

How long have you used tobacco? _____

If you currently do not use tobacco, but have in the past, describe how much and how long you used tobacco:

Alcohol / Drug Use

Do you currently drink alcohol? No _____ Yes _____

If yes, specify the type and number of drinks per day or per week: _____

For how long (since what age)? _____

If you currently do not drink alcohol, but did in the past, describe how much and how long you drank in the past:

Have you ever tried or taken recreational or street drugs? No ___ Yes ___ (if yes circle all below)

- Marijuana, Pot, Grass, Weed, Blunt, Dope, Joint, Hashish, Hash, THC, Reefer
- Cocaine, Coke, Crack, Rock, Powder, Flake, Snow, Snorting, IV, Freebase, Speedball
- Amphetamine, Speed, Crystal, Meth, Crank, Glass, Rush, Dexedrine, Ritalin, Adderall, Diet Pills
- Codeine, Heroin, Morphine, Opium, Lortab, Methadone, OxyContin, Percodan, Dilaudid, Demerol, Vicodin
- LSD, Acid, Mescaline, Ketamine, PCP, Angel Dust, STP, Mushrooms, Ecstasy, MDMA, MDA
- Glue, Paint Thinner, Gasoline, Nitrous Oxide, Laughing Gas, Ethyl Chloride, Amyl or Butyl Nitrate, Poppers
- Quaalude, Ludes, Barbs, Amytal, Seconal, Benzodiazepine, Valium, Xanax, Librium, Ativan, Dalmane
- Halcion, Rohypnol, GHB, Downers, Sleeping Pills

Other recreational or street drugs: _____

First use / frequency / last use of circled drugs: _____

Have you ever received treatment to help you stop taking drugs or abusing alcohol?
No ___ Yes ___ (explain) _____

Have you ever had any of the following because of your use of alcohol and/or drugs?

Relationship problems No ___ Yes ___ (explain) _____

Job problems No ___ Yes ___ (explain) _____

Legal problems No ___ Yes ___ (explain) _____

Mental Health

Have you ever experienced significant anxiety, depression, suicidal or homicidal feelings or attempts in the past or presently? No ___ Yes ___ (explain below)

Have you ever had a mental health evaluation; treatment from a counselor, social worker, psychologist, psychiatrist, or church leader; or related hospitalization? No ___ Yes ___ (explain below)

Please describe any past or current psychological or psychiatric treatment below:

Type of Treatment	Age at that time/Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social and Family History

Have you ever served in the military? No ___ Yes ___

If yes, what branch of the military were you in? _____ Years served: _____

Highest Rank/position: _____ Type of Discharge: _____

Have you ever been arrested? No ___ Yes ___ (Charges?) _____

Do you have a valid driver's license? Yes ___ No ___ (explain) _____

Do you currently drive? Yes ___ No ___ (explain) _____

What are your hobbies, interests, or favorite activities? _____

Hand you write with: _____ Left-handed family members?: _____

Anyone in your family receive mental health treatment or been hospitalized for mental health reasons?

No ___ Yes ___ (explain) _____

Please list the people currently living you:

NAME	AGE	RELATIONSHIP

Parental Information:

Mother's highest level of education: _____ Occupation: _____

Medical/Psychiatric Problems: _____

Father's highest level of education: _____ Occupation: _____

Medical/Psychiatric Problems: _____

Educational History:

Highest grade completed: _____ GED?: _____

College or University Education: No _____ Yes _____ (if yes specify below)

Degree: _____ Major/Area: _____ Years: _____ Semester Hours: _____

Institution Name: _____ Location: _____

Technical or Vocational Training (if any): _____

Typical Grades on Report Card: _____

Skipped any grades? No _____ Yes _____ (explain) _____

Repeated any grades? No _____ Yes _____ (explain) _____

Special education classes, tutoring, or alternative school placement (if any): _____

Easiest subjects: _____ Difficult subjects: _____

Employment History

Are you currently employed?

No ___ How long? _____ Reason for unemployment: _____

Yes ___ How long at your present job? _____ Describe your job: _____

Please describe your past jobs:

DATES WORKED	JOB TITLE	JOB DUTIES	REASON FOR LEAVING

How did you sleep the night before this evaluation? _____

Additional information that you believe is important for us to know when interpreting your test results:

