NORTHWEST neuro behavioral INSTITUTE

ADULT HISTORY

(This information will be included in the final report)

Patient's Name____

Age________ Birthdate________ Sex________ Education________

Primary Language____________________ Secondary Language___________________

Hand used for writing: (check one) Right________ Left________

Foot used for kicking: (check one) Right________ Left________

Medical diagnoses (if any) (1)____

(2)___________________________________ (3)_______________________________

Who referred you for this evaluation:____

Briefly describe problem(s)____

____

____

____

When did the problem(s) begin?____

If an accident occurred, what was the date of the accident?_________________________

What specific questions would you like answered by this evaluation?:

(1)____

(2)____

(3)____

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SYMPTOM SURVEY

For each symptom that applies, place a check mark on the line. Add any helpful comments next to the line.

Date of Onset

1) PROBLEM SOLVING

___ Difficulty figuring out how to do new things ___________
___ Difficulty planning ahead ___________
___ Difficulty figuring out problems that most other people can do ___________
___ Difficulty thinking as quickly as needed ___________
___ Difficulty doing things in the right order (sequence problems) ___________
___ Difficulty verbally describing the steps in doing something ___________
___ Difficulty changing a plan or activity when necessary ___________
___ Difficulty completing an activity in a reasonable amount of time ___________
___ Difficulty doing more than one thing at a time ___________
___ Difficulty switching from one activity to another activity ___________
___ Impulsivity ___________
___ Easily frustrated ___________
___ Other problem solving difficulties___________________________________

2) SPEECH, LANGUAGE, AND MATH SKILLS

___ Difficulty finding the right word to say ___________
___ Difficulty understanding what others are saying ___________
___ Unable to speak ___________
___ Difficulty staying with one idea ___________
___ Difficulty writing letters or words (not due to motor problems) ___________
___ Slurred speech ___________
___ Odd or unusual speech sounds ___________
___ Difficulty with math (e.g., checkbook balancing, making change) ___________
___ Difficulty understanding what I read ___________
___ Difficulty speaking ___________
___ Other speech, language, or math problems_____________________________

3) NONVERBAL SKILLS

___ Difficulty telling right from left ___________
___ Difficulty doing things I should automatically be able to do
(e.g., brushing teeth, etc.) ___________
___ Difficulty drawing or copying ___________
___ Difficulty dressing (not due to physical difficulty) ___________

___ Difficulty finding my way around places I've been to before ____________
___ Difficulty recognizing objects or people ____________
___ Parts of my body do not seem as if they belong to me ____________
___ Unaware of things on one side of my body: Right___ Left___ ____________
___ Decline in my musical abilities ____________
___ Not aware of time (e.g., time of day, season, year) ____________
___ Slow reaction time ____________

___ Other nonverbal problems____

4) CONCENTRATION AND AWARENESS

___ Highly distractible ____________
___ Difficulty focusing ____________
___ Lose my train of thought easily ____________
___ Difficulty finishing what I start ____________
___ Become easily confused and disoriented ____________
___ Blackout spells (fainting) ____________
___ My mind goes blank ____________
___ Aura (strange feelings) ____________
___ Don't feel very alert or aware of things ____________
___ Motor restlessness (e.g., foot tapping, difficulty sitting still) ____________
___ Other concentration or awareness problems_______________________________

5) MEMORY

___ Forgetting where I leave things (e.g., keys, gloves, etc.) ____________
___ Forgetting names ____________
___ Forgetting what I should be doing ____________
___ Forgetting where I am or what I am doing ____________
___ Forgetting events that happened quite recently (e.g., last meal) ____________
___ Need someone to give me a hint so I can remember things ____________
___ Relying more and more on notes to remember things ____________
___ Forgetting the order of things (e.g., when cooking, etc.) ____________
___ Forgetting facts, but I can remember how to do things ____________
___ Forgetting how to do things, but I can remember facts ____________
___ Forgetting faces of people I know (when they are not present) ____________
___ Frequently forgetting appointments ____________
___ Other memory problems____

6)	MOTOR AND COORDINATION	Check the side this occurs on:			
		Right	Left	Both	
___	Fine motor control problems (using a key, pencil, etc.)	____	____	____	____________
___	Weakness on one side of my body	____	____	____	____________
___	Difficulty holding onto things	____	____	____	____________
___	Tremor or shakiness	____	____	____	____________
___	Muscle tics or strange movements	____	____	____	____________
___	My writing is very small				____________
___	My writing is very large				____________
___	Walking more slowly than other people				____________
___	Feeling stiff				____________
___	Balance problems				____________
___	Difficulty starting to move				____________
___	Jerky muscles				____________
___	Muscles tire quickly				____________
___	Often bumping into things				____________
___	Other motor or coordination problems				____________

7)	SENSORY	Check the side this occurs on:			
		Right	Left	Both	
___	Loss of feeling or numbness	____	____	____	____________
___	Tingling or strange skin sensations	____	____	____	____________
___	Difficulty telling hot from cold	____	____	____	____________
___	Problems seeing on one side	____	____	____	____________
___	Blurred vision	____	____	____	____________
___	Blank spots in vision	____	____	____	____________
___	Brief periods of blindness	____	____	____	____________
___	See “stars” or flashes of light	____	____	____	____________
___	Double vision	____	____	____	____________
___	Difficulty looking quickly from one object to another object				____________
___	Need to squint or move closer to see clearly				____________
___	Losing hearing				____________
___	Ringing in my ears or hearing strange sounds				____________
___	Difficulty tasting food				____________
___	Difficulty smelling				____________
___	Smelling strange odors				____________
___	Other sensory problems ____				

8) PHYSICAL

___	Headaches	__________
___	Dizziness	__________
___	Nausea or vomiting	__________
___	Urinary incontinence	__________
___	Loss of bowel control	__________
___	Excessive tiredness	__________
___	Sensitivity to bright lights	__________
___	Sensitivity to loud noises	__________
___	Other physical problems______________________________________	

9) BEHAVIOR Check all that apply to you in the past 6 months:

		Rate Severity:			
		Mild	Moderate	Severe	
___	Sadness or depression	____	____	____	__________
___	Anxiety or nervousness	____	____	____	__________
___	Stress	____	____	____	__________
___	Sleeping problems:	____	____	____	__________
	(Falling asleep_____Staying asleep_____)				
___	Become angry more easily				__________
___	Euphoria (feeling on top of the world)				__________
___	Much more emotional (e.g., cry more easily)				__________
___	Feel as if I just don't care anymore				__________
___	Doing things automatically (without awareness)				__________
___	Less inhibited (do things I would not do before)				__________
___	Difficulty being spontaneous				__________
___	Change in eating habits______________________________________				
___	Increase in weight_______Decrease in weight_______				__________
___	Change in interest in sex______________________________________				
___	Loss of energy				__________
___	Increase in energy				__________
___	Experience nightmares on a daily/weekly basis				__________
___	Lack of interest in pleasurable activities				__________
___	Increase in irritability				__________
___	Increase in aggression				__________
___	Other recent changes in behavior or personality				__________

Overall, my symptoms have developed:__________Slowly __________Quickly

My symptoms occur:__________Occasionally __________Often

Over the past 6 months my symptoms have:______Stayed the same ______Worsened

In summary, there is: _____Definitely something wrong with me
_____Possibly something wrong with me
_____Nothing wrong with me

EARLY HISTORY (Complete all that you can for this section)

You were born:_____On time _____Prematurely _____Late

Your weight at birth: _____lbs. _____oz.

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

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

___Accident (describe)____
___Alcohol use
___Cigarette smoking
___Drug use (marijuana, speed, cocaine, LSD, etc.)
___Illness (toxemia, diabetes, high blood pressure, infection, 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 (nuclear plant, industrial area, pesticide sprayed area, etc.)?
_____Yes _____No Describe____

Rate your developmental progress as it has been reported to you, by checking one description for each area:

	Early	Average	Late
Walking			
Language			
Toilet training			
Overall development			

As a child, did you have any of these conditions: (Check all that apply)

___Attentional problems
___Clumsiness
___Developmental delay
___Learning disability
___Speech problems
___Muscle tightness or weakness
___Loss of consciousness
___Other psychiatric difficulty___________________________________
___Other problems____
____

___Head injury
___Hearing problems
___Hyperactivity
___Frequent ear infection
___Vision problems
___Depression

MEDICAL HISTORY

CHILDHOOD MEDICAL HISTORY

Check all the conditions that were diagnosed when you were a child. Add any helpful details (age at diagnosis, treatment provided, etc.):

___Concussion
___Scarlet fever

___Brain infection or disease
___Rheumatic fever
___Cerebral palsy
___Chicken pox
___Colds (excessive)
___Oxygen deprivation
___Tuberculosis
___AD/HD or ADD

___Epilepsy or seizures
___Fevers (104°F or higher)

___Heart problems
___Immune system disease
___Kidney problems
___Lung (respiratory problems)
___Venereal disease
___Whooping cough
___Encephalitis
___Learning difficulties/disability

___Pneumonia
___Poisoning

___Polio
___Cancer
___Asthma
___Diabetes
___Measles
___Meningitis
___Allergies

___Other disease or disabilities____
____
____

As a child, were you exposed to excessive amounts of lead (e.g., eating paint chips, living next to high concentration of automobile exhaust fumes, etc.)? _____Yes _____No
If yes, explain____
____

As a child, did you have an accident that required a hospital visit? _____Yes _____No
If yes, explain____
____

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 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

(Check all that apply)

___AIDS or HIV+
___Allergies
___Ateriosclerosis (artery disease)
___Arthritis
___Blood disorder

___Brain disease or infection
___Cancer or chemotherapy
___Parkinson's disease
___Psychiatric problems
___Dementia
___Venereal disease
___Hazardous substance exposure
___Concussion

___Heart disease
___Huntington's disease
___Hypertension
___Kidney disease
___Loss of consciousness

___Lung (respiratory) disease
___Malnutrition
___Meningitis
___Multiple Sclerosis
___Polio
___Radiation exposure or therapy
___Thyroid disease
___Head injury

___Any other problems____
____

List any medications you currently take (prescribed or over-the-counter) and dosage:
____
____
____
____

Do you have epilepsy or a seizure disorder? _____Yes _____No

If yes, check the one you have been diagnosed with:

Partial	Generalized	Unclassified_____
___Simple partial	___Absence (Petit mal)	
___Complex partial	___Myoclonic	
___Partial evolving into generalized	___Clonic	
	___Tonic	
	___Atonic	
	___Tonic-Clonic (Grand mal)	

___I have a seizure disorder but don't know which type. Please describe it____________
____
____

Are you currently in psychotherapy or under psychiatric care? _____Yes _____No

Have you ever been in psychotherapy or under psychiatric care? _____Yes _____No
If yes, when and with whom?____
____
____
____

Have you ever been prescribed psychotropic medication (e.g., antidepressant, anti-anxiety, tranquilizer)? If yes, what____
____
____

List all inpatient hospitalizations including the name of the hospital, dates of hospitalization, duration, and diagnosis____
____
____
____

MEDICAL TESTING

Check all the medical tests that recently have been done and report any abnormal findings:

	Check if normal	Abnormal findings
___Angiography	____________	______________________
___Blood Work	____________	______________________
___Brain SPECT	____________	______________________
___CT Scan of head	____________	______________________
___MRI	____________	______________________
___PET scan	____________	______________________
___EEG	____________	______________________
___Lumbar puncture	____________	______________________

___Neurological Exam ______________ __________________________
___Physician's Office Exam ______________ __________________________
___Ultrasound ______________ __________________________
___Other________________ ______________ __________________________

Who is your primary care physician?____

Date of last vision exam?____

Date of last hearing exam?____

Have you had a prior psychological or neuropsychological evaluation? ___Yes ___No
If yes, who was the psychologist?____
Date of evaluation____

Findings of evaluation____
____
____

SUBSTANCE USE HISTORY

I began drinking alcohol regularly at age:
___Prior to age 10 ___10-15 ___16-18 ___19-21 ___over 21

I drink alcohol: rarely or never_____ 1-2 days/week_____
3-5 days/week_____ daily_____

I used to drink alcohol but have stopped_____ Date stopped____________________
Preferred types of drinks____

Usual number of drinks I have at one 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 (e.g., fights, legal problems, conflicts, problems at work, accidents, etc.) after drinking
___I sometimes black out after drinking
Please check all the drugs you are now using or have used in the past:

	Presently using	Used in past
Amphetamines (including diet pills)	_____________	___________
Barbiturates (downers, etc.)	_____________	___________
Cocaine or crack	_____________	___________
Hallucinogenics (LSD, acid, STP, etc.)	_____________	___________
Inhalants (glue, nitrous oxide, etc.)	_____________	___________
Marijuana	_____________	___________

Opiate Narcotics (heroin, morphine, etc.) ____________ __________
PCP (angel dust) ____________ __________
Other drugs____

Do you consider yourself dependent on any of the above substances? ____Yes ____No

Do you consider yourself dependent on any prescription drugs? ____Yes ____No

Check all that apply:
___I have gone through drug withdrawal
___I have used I.V. drugs
___I have been in drug treatment

Do you smoke? _____Yes; amount per day__________________ _____No

Do you drink coffee? _____Yes; amount per day__________________ _____No

LEGAL/CRIMINAL HISTORY

Describe any history of arrests, charges, convictions:
____

____

____

FAMILY HISTORY

The following questions deal with your biological family members.

MOTHER

Is she alive? _____Yes _____No If deceased, what was the cause of death?
____

Mother's occupation____

Mother's highest level of education____

Does/did your mother have a known or suspected learning difficulty? ____Yes ____No
If yes, describe____

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FATHER

Is he alive? _____Yes _____No If deceased, what was the cause of death?
____

Father's occupation____
Father's highest level of education____

Does/did your father have a known or suspected learning difficulty? ____Yes ____No
If yes, describe____

How many siblings do you have? ________________

What are their ages? ____

Are there any problems (physical, academic, psychological) associated with any of your siblings? If yes, describe____
____

How many children do you have? _____Girls Ages_________________________
_____Boys Ages_________________________

Are there any problems (physical, learning, behavior, psychological) associated with any of your children? If yes, describe ____
____

Marital status: _____Single _____Partnered _____Married
_____Divorced _____Widowed

How many times have you been married? _____________

Spouse's age__________Spouse'soccupation___________________________________

How is your spouse's health? _____Excellent _____Average _____Poor

EDUCATIONAL HISTORY

How would you describe your usual performance as a student?

___A & B
___B & C
___C & D
___D & F

Please provide any additional helpful comments about your academic performance____
____
____
____

Highest grade or degree you've earned____

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What was your best subject(s)? ____
What was your weakest subject(s)? ____

Were you ever held back to repeat a grade? _____Yes _____No
If yes, what grade?________________________Or age?_________________________

Were you ever in any special class (es) or did you receive special education services?
_____Yes _____No If yes, what grade__________Or age? __________
What type of class? ____

OCCUPATIONAL HISTORY

Current job title_____________________________Years in this position____________

Salary: _____Under $10,000 _____$10,000-$29,900
_____$30,000-$50,000 _____Over $50,000

How long have you been at this job? ____

Current job responsibilities____

Prior jobs (start with most recent):
____
____
____

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 military duties____

Did you sustain any physical injuries in the military? _____Yes _____No
If yes, describe____

Were you ever exposed to any dangerous or unusual substances during your service?
_____Yes _____No If yes, explain___________________________________

RECREATION

Briefly list the types of recreation you enjoy___________________________________
____

OTHER INFORMATION

Please provide other information you think may be important______________________
____
____
____

Thank you for taking the time to carefully complete this questionnaire.