LISTENING, LEARNING DEVELOPMENT CENTRE

All information collected is confidential and is protected. We will not share information with other parties without written consent.

Date:_____

Adult Neuropsychological History

Name of person filling out form _____ Relationship to patient _____
Patient Name:_____ Sex:_____ Age:_____
Date of Birth:_____ Employer:_____
Address:_____
Home Phone:_____ Work Phone:_____ _____
Referred By:_____ Reason For Referral:_____

History of Present Injury/Illness

Date of Injury/Illness: _____

Please describe onset of injury/illness, dates, names of hospitals and physicians, operations, types of treatment, etc.:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

A. Symptom Survey

Place a check beside each symptom that currently applies. Please also circle the symptom if it existed previous to the injury/illness.

1. PHYSICAL

__ Headaches
__ Nausea
__ Urinary incontinence
__ Excessive tiredness
__ Pain (Indicate location): _____
__ Other physical problems: _____
__ Dizziness
__ Vomiting
__ Loss of bowel control
__ Blackout spells (fainting)

2. SENSORY

Check the side this occurs on:

	Right Side	Left Side	Both Sides
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			
Seeing "stars" or flashes of light			
Difficulty hearing			
Ringing in ears			
Hearing strange sounds			
Difficulty tasting food			
Difficulty smelling			
Smelling strange odors			
Double vision			
Difficulty looking quickly from one object to another object			
Other sensory problems (describe)			

3. MOTOR AND COORDINATION

Check the side this occurs on:

	Right Side	Left Side	Both Sides
Fine motor control problems (using a pencil)			
Weakness on one side of body			
Difficulty holding on to things			
Tremor or shakiness			
Muscle tics or strange movements			
Writing is very small			
Writing is very large			
Walking more slowly than other people			
Jerky muscles			
Difficulty starting to move			
Muscles tire quickly			
Often bumping into things			
Other motor or coordination problems (describe)			

4. NONVERBAL SKILLS

__ Difficulty telling right from left
__ Problems drawing or copying
__ Difficulty recognizing objects or people
__ Gets lost easily
__ Problems finding way around places that you been before
__ Slow reaction time
__ Unaware of things on one side of your body: [ ] Right side [ ] Left side
__ Difficulty doing things that s/he should automatically be able to do (e.g., brushing teeth)
__ Seems unable to recognize facial or body expressions of disapproval or emotions
__ Difficulty with puzzles, Legos, blocks, or similar games
__ Other nonverbal problems:_____

5. SPEECH, LANGUAGE AND ACADEMIC SKILLS

__ Unable to speak
__ Slurred speech
__ Difficulty spelling
__ Difficulty with math
__ Odd or unusual speech sounds
__ Difficulty finding the right words to say
__ Difficulty expressing thoughts in an organized way
__ Difficulty staying with one idea during a conversation
__ Difficulty reading phonetically
__ Difficulty understanding what others are saying
__ Difficulty with reading comprehension
__ Difficulty writing letters or words (not due to motor problems)
__ Difficulty verbally describing the steps involved in doing something
__ Other speech, language, or academic skills problems:_____

6. CONCENTRATION AND AWARENESS

__ Highly distractible
__ Problems concentrating
__ Mind appears to go blank at times
__ Other concentration or awareness problems:_____
__ Loses train of thought
__ Becomes easily confused or disorientated
__ Doesn't appear very alert or aware of things

7. PROBLEM SOLVING

__ Difficulty with reasoning or figuring out how to do new things
__ Difficulty with planning and organization
__ Difficulty figuring out problems that a younger child can do
__ Difficulty thinking as quickly as needed
__ Difficulty doing things in the right order (sequencing problems)
__ 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
__ Other problem solving difficulties: _____

8. MEMORY

__ Forgetting where you leave things (e.g., toys or books)
__Forgetting what you should be doing
__Forgetting events that happened quite recently (e.g., last meal)
__Forgetting events that happened long ago (months or years)
__Needs someone to give a hint so you can remember
__Relying more and more on notes or reminders to remember things
__Forgetting the order of things (e.g., when putting something together, etc.)
__Other memory problems
__ Forgetting names
__Forgetting where you are or where you are going

9. BEHAVIOR AND EMOTIONAL FUNCTIONING

__ Suicidal thoughts
__ Loss of appetite
__ Difficulty sleeping
__ Anxiety/nervousness
__ Excessive fears or phobias
__ Poor frustration tolerance
__ Explosive anger
__ Feeling worthless
__ Sexual problems
__ Quiet
__ Emotional
__ Is very fidgety
__ Is cruel to animals
__ Answers before you hears the whole question
__Other unusual behavior: _____
__ Depression/sadness
__ Weight loss
__ Apathy
__ Nightmares
__ Dependent
__ Unmotivated
__Rapid mood changes
__Feelings of hopelessness
__Anorexia or Bulimia
__Resists change
__Immature
__Can't remain seated
__Destroys other people's property
__ Recurrent/intrusive thoughts
__ Overeating Weight gain
__ Homicidal thoughts
__ Recurrent/intrusive disturbing recollections or dreams
__ Overwhelming need to perform certain behaviors/rituals
__ Significant concerns with physical problems
__ Fatigue
__ Poor self-esteem
__ Loss of interest in almost all activities
__ Wetting bed or clothes
__ Bowel movements in underwear
__Can't wait your turn

10. ACTIVITIES OF DAILY LIVING

__ Difficulty dressing __ Difficulty bathing or showering __Requires assistance for toileting
__ Problems telling time __ Problems keeping track of time (i.e. resulting in missed or late arrival for work or classes)
__ Unable to drive safely __ Unable to ride a bicycle safely in traffic
__ Difficulty with grooming (including not attending to the same level of grooming as before)
__ Difficulty with eating or feeding self independently, or not attending to table manners as before
__ Unable to use of public transportation independently (i.e. school bus for children; city bus or taxi for and adult)
__ Problems preparing a simple meal (i.e. sandwich) independently or using a microwave oven for frozen meals
__ Problems preparing a complex meal (i.e. complete meal using the stove/oven) independently
__ Difficulty preparing a list and shopping independently
__ Problems handling cash purchases (i.e. making change)
__ Problems writing checks or balancing a checkbook
__ Difficulty managing household/personal finances
__ Difficulty independently initiating or performing household chores

B. Medical History

Please check all the conditions that have been diagnosed as a child or an adult.

__ AIDS, ARC or HIV+
__ Allergies
__ Arthritis
__ Asthma
__ Abscessed ears
__ Arteriosclerosis
__ Bleeding disorder
__ Blood disorder
__ Broken bones
__ Brain disease/infection
__ Cerebral palsy
__ Colds (excessive)
__ Chicken pox
__ Carbon monoxide poisoning
__ Cancer
__ Diabetes
__ Enzyme deficiency
__ Encephalitis
__ Ear Infections
__ Fevers (104 or higher)
__ Genetic disorder
__ Head injury or concussion
__ Heart problems
__ Hereditary disorder
__ Headaches
__ Hearing problems
__ Immune system disease
__ Jaundice
__ Kidney problems
__ Liver disorder
__ Lung disease
__ Lead poisoning
__ Leukemia
__ Metabolic disorder
__ Meningitis
__ Measles
__ Mumps
__ Poisoning
__ Polio
__ Parkinson's Disease
__ Rheumatic Fever
__ Radiation exposure/therapy
__ Scarlet fever
__ Senility (Dementia)
__ Stroke or TIA
__ Tuberculosis
__ Tumor
__ Thyroid disease
__ Huntington's disease
__ Hypertension
__ Hormone problems
__ Hazardous substance exposure
__ Malnutrition
__ Multiple sclerosis
__ Oxygen deprivation
__ Pneumonia
__ Venereal disease
__ Vision problems
__ Whooping cough

Have you ever been diagnosed with epilepsy or a seizure disorder? ___ Yes ___ No If yes, please indicate which one:
PARTIAL: ___ Simple partial (Jacksonian) ___ Complex partial (Psychomotor) ___ Partial evolving into generalized
GENERALIZED: ___ Absence (Petit mal) ___ Myoclonic ___ Clonic ___ Tonic ___ Tonic-clonic (Grand mal) ___ Atonic
___ UNCLASSIFIED TYPE

Other medical/physical problems_____

List any medications currently being taken (over-the-counter or prescription), and the dosage.

Medication and Dosage:

_____ _____
_____ _____
_____ _____

List any medications you are ALLERGIC or sensitive to: _____

Past Hospitalizations: (When, where, and for what)

_____
_____
_____
_____
_____

Outpatient Surgeries: (When, where and for what)

_____
_____
_____

C. Psychiatric History

Indicate which stressors you are experiencing currently (within the last 6 months) or in the past.

	Now	Past
Death of spouse		
Illness of friend		
Marital separation		
Conflicts with family		
New job		
Business difficulties		
Change in residence		
Incest/sexual abuse		
Other problems:		

Are you **currently** receiving therapy?_____ From who?_____
When did you start therapy?_____ For what problems(s)?_____
_____
List current psychiatric medications:_____

Have you received therapy **in the past**?_____ From who?_____
When (Start and finish):_____ For what problem(s)?_____
List past psychiatric medications:_____

Have you been hospitalized for psychological problems? _____ When? _____
Where were you hospitalized?_____
Have you ever attempted suicide?_____ When?_____
How?_____

Circle substances you **currently** use (Even if only occasionally or in small amounts):

Alcohol Tobacco Marijuana Barbiturates ("Downers") Tranquilizers Amphetamines ("Speed") Crank Crack Cocaine
Opiates (Heroin, Opium, Codeine, etc.) Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) PCP ("angel dust")
Other: _____

Circle substances you have taken **in the past** (Even if only occasionally or in small amounts):

Alcohol Tobacco Marijuana Barbiturates ("Downers") Tranquilizers Amphetamines ("Speed") Crank Crack Cocaine
Opiates (Heroin, Opium, Codeine, etc.) Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) PCP ("angel dust")
Other: _____

Have you had a prior psychological or neuropsychological evaluation? Yes ___ No ___
If yes, complete this information:
Name of psychologist: _____
Address: _____Phone: _____
Date of and reason for this evaluation:_____
Findings of the evaluation: _____

D. Birth and Developmental History

Place of Birth: _____ Were parents married at time of birth? _____
Was your mother under a doctor's care during the pregnancy? ____
Were you adopted? _____ If so, at what age? ____

Circle any illnesses during pregnancy: Anemia Toxemia Herpes Measles German measles Bleeding Kidney disease
Heart disease Hypertension Abdominal trauma Infection Diabetes

Medications taken during pregnancy:_____
Were drugs or alcohol taken during pregnancy? Yes ___ No ___ If yes, specify:_____
Was there significant emotional stress during pregnancy? Yes ___ No ___ If yes, name stressors: _____

Was the birth: __ On time __ Premature (By how long _____) __ Late (By how long _____)
Was labor: __ Spontaneous __ Induced ___ Duration of labor_____ (Hours) Cesarean required?_____
Was the presentation: __ Normal ___ Breach ___ Transverse (Crosswise) ___ Posterior first

Did the baby experience any of these problems:
__ Fetal distress __ Prolapsed cord __ Low placenta (Placenta previa)
__ Premature separation of the placenta (Abruptio placenta) __ Cord wrapped around neck
__Any other problems that mother or child had: _____

Was general anesthesia used? ____ Were forceps used? ___ Were there breathing problems? _____
Color at birth: __ Normal __Blue __ Yellow __ Was oxygen used (How long)?_____ APGAR Score _____
Birthweight:_____ Length:_____

Circle those that apply to the first few weeks after birth:
Excessive sleeping Laziness Irritability Excessive crying Stiffness Limpness Tremors Twitching Feeding difficulties
Vomiting Jaundice Other_____

Transfusions required?____ Medication required? (For what)_____
Surgery required? (For what)_____

Give approximate ages that developmental milestones were achieved:

Head control _____	Run _____	Toilet trained _____
Rolled over _____	Said first word _____	Dress self _____
Sat alone _____	Used sentences _____	Tie shoes _____
Walked _____	Self feeding with utensils _____	Color within lines _____

Circle any problems that occurred in later development:
Hearing Speaking Stuttering Reading Writing Spelling Arithmetic Behavior Hyperactivity Attentional difficulties Seizures Coordination

List family members with developmental or learning problems:_____

E. Family History

Father's Name _____ Age _____
Health Problems _____ Education _____
Occupation _____ Employer _____

Mother's Name _____ Age _____
Health Problems _____ Education _____
Occupation _____ Employer _____

Date of parent's marriage _____ Years married _____ Current marital problems? _____
If separated, give date _____ If divorced, date_____ Previous marriages? (Father)_____(Mother)_____
Subsequent marriages?(Father)_____(Mother)_____

If divorced, current custody arrangement _____

Please provide information regarding step-parents if your parents are divorced:

Name Age Education Occupation Date Married # Years _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____

Names and ages of brothers and sisters (Include step-brothers and step-sisters):
_____
_____
_____

List anyone else who lived in the home during your childhood:
_____

List names of any family members (E.G. Immediate and distant relatives) with any of the following problems:

Alcohol/drug abuse _____Criminal history _____
Emotional/behavioral problems _____ Learning/developmental problems _____
Medical problems (e.g. Heart disease, Cancer, Seizures) _____