Neuropsychological Associates of California

GENERAL HISTORY FORM

SELF-ADMINISTERED / CLINICIAN ADMINISTERED [circle]
Revised January, 2015

PLEASE COMPLETE THIS FORM AS CAREFULLY AS YOU CAN. PRINT CLEARLY WHEN YOU WRITE IN INFORMATION. OTHERWISE YOU NEED ONLY CIRCLE OR CHECK TO INDICATE YOUR ANSWER.

NAME:_____ DATE:_____

Age:____ Birth Date:_____/_____/_____ Social Security #:_____-_____-_____ Gender <circle>: M F

I consider myself to be <circle>: Right Left Handed - I use either hand equally, but write with my Right / Left

I completed _____ years of formal education. Ethnicity: <circle> African-Amer Asian Hisp Pacific Isl White

Primary language: <circle> English Spanish Other (please specify) _____

My Marital Status is <circle> single-never married single-with partner married married-separated divorced widowed [When?] _____ Notes:_____

My Address is: _____
Street City State ZIP

My Phone Number is : Area Code: (_____) _____ Extension? _____

My FAX Number [if applicable] is : (_____) _____

Members in my household: _____

Did Someone Refer You? <circle> NO YES: Name of Referral Source: _____

Address: _____

Phone: (_____)_____ FAX: ( )_____ ***e-mail***: _____

REASON[S] FOR TESTING:

Is this evaluation part of a lawsuit or criminal charge? N Y <circle> LAWSUIT LPS/CONSERV CRIMINAL

Who arranged this exam? my doctor my attorney **the "other side's" attorney the district attorney the judge**

IS THE REASON FOR REFERRAL AN INJURY or ACCIDENT or ILLNESS? <circle> NO YES

DATE OF INJURY / ACCIDENT / ILLNESS: _____ [or when your symptoms started]

BRIEF SUMMARY OF YOUR MAIN COMPLAINTS: <Indicate your main complaint[s] first, then your other complaints>

If you were in an accident and that's why you're being tested, describe how your problems began and the major problem[s] you had at first and are now experiencing; [continue on page 15-16 if needed]

_____

_____

_____

_____

_____

_____

_____

_____

_____

BACKGROUND INFORMATION:

I was BORN in : _____ I lived in _____ during most of my childhood.

PARENTS: My Mother is LIVING; her age is: _____ Her health is: Excellent Good/Normal Fair Poor

My Mother is DECEASED. She passed away in 19____ 200_ Her age was: _____

Cause? _____

My Father is LIVING; his age is: _____ His health is: Excellent Good/Normal Fair Poor

My Father is DECEASED. He passed away in 19____ 200_ His age was: _____

Cause? _____

My MARITAL STATUS is <circle>: MARRIED SEPARATED SINGLE, NEVER MARRIED DIVORCED

WIDOWED DIVORCED + REMARRIED SINGLE, BUT LIVING WITH A PARTNER other: _____

Details of Marriage[s]: I have been married a total of: ___ times [if more than 4 times, continue on p.16]

Year of marriage #1: _____ to: _____ RESULT? <circle> NOW MARRIED DIVORCED DEATH of SPOUSE

Year of marriage #2: _____ to: _____ RESULT? <circle> NOW MARRIED DIVORCED DEATH of SPOUSE

Year of marriage #3: _____ to: _____ RESULT? <circle> NOW MARRIED DIVORCED DEATH of SPOUSE

Year of marriage #4: _____ to: _____ RESULT? <circle> NOW MARRIED DIVORCED DEATH of SPOUSE

Do You Have CHILDREN? <circle> NO YES _____Males [ages: _____] _____Females [ages: _____]

Do any of your CHILDREN live with you now? <circle> NO YES Which ones? _____

Any Health Problems for CHILDREN? NO YES <specify> _____

Comments:_____

SIBLINGS: I have [had] _____ brothers and _____ sisters [include all natural siblings, living or not living]

I have _____ half-brothers and _____ half-sisters SERIOUS HEALTH PROBLEMS? NO YES

OLDEST ( ) YOUNGEST ( ) MIDDLE ( ) OTHER ( ) _____

Comments:_____

SOCIAL HISTORY:

BIRTH and EARLY DEVELOPMENT: Information source: Examinee Family Member Medical Records

During pregnancy with you, was your mother a heavy: <circle> drinker drug user smoker NONE OF THESE

Was she physically ill / mentally ill? YES NO Was she physically abused? YES NO

Were you a full-term baby? <circle> YES NO Premature by: _____months Routine Delivery? YES NO

Were you considered a normal, healthy baby? <circle> YES NO <specify> _____

As far as you know, did you learn to walk, talk, and use the toilet as soon as you should have? <circle>

AS FAR AS I KNOW NOT SURE NO, I WAS SLOW LEARNING TO: <circle> Walk Talk Use Toilet

DEVELOPMENTAL MILESTONES GUIDE: *NORMAL ATTAINMENT AGES*:

MOTOR: Held Head Up:1 mo Sat Up:7-10 mos Stood Up: 1 yr Walked: 1.5 yrs Ran, Climbed Stairs: 2yrs

TALK: Vocalized: 6 mos Vocalized To Name: 7-11 mos 1Word: 11-12 mos 2-Word Sent: 1-2yrs Complete Sentence: 2-3 yrs

TOILET: Day Urination Control: 2.5 yrs Night Urination Control + Bowel Control: 4 yrs

Did you have any unusual diseases [besides mumps, measles, chicken pox]? <circle> NO YES <specify>

Disease: _____ at age: _____ || Disease: _____ at age: _____

Disease: _____ at age: _____ || Disease: _____ at age: _____

AS A CHILD: Head Trauma ( ) Loss of Consciousness ( ) Concussion ( ) Exposure to Toxins ( )

Hospitalizations: Yes ( ) No ( ) ***If yes, explain:***_____

CHILDHOOD and ADOLESCENCE:

Were you physically / mentally / sexually abused as a child or adolescent? YES NO POSSIBLY [explain below]

Were there problems / stresses in the home? <circle> NO YES: broken home death of parent serious illness

Did you have a normal social life? YES NO Normal number of friends? YES NO

Were you considered <circle> "different" introverted hostile, aggressive hard to manage / control

How old were you when you began dating? _____yrs _____ grade

EXPLAIN: _____

< if needed, give additional details on Page 15-16 >

EDUCATION: I have completed _____ years of formal education [high school = 12 + any college]*

<details> *[count no more than 4 years for college; 2 years for a Masters; 5 years for Ph.D. / M.D. / Ed.D.]

I have the following degree[s]: High School Diploma /GED AA BA/BS MA/MS PhD/MD/EdD Other: _____

Usual or Typical Grades/GPA [H.S. / College]: <circle> A B C D F Grade Point Average in College: _____

High School Attended: _____ Where? _____ yrs:___ to: ___

College[s] Attended:_____ Major[s]: _____ yrs: ___to ___

College[s] Attended:_____ Major[s]: _____ yrs: ___to ___

NOTES: _____

Ever been told you had a Learning Problem? N Y If "Y" What type? READING SPELLING WRITING MATH

Ever been told you had an Attention Deficit Disorder [ADD or ADHD] ? N Y If "Y" At what age? _____

Who tested you or made this diagnosis? TEACHER COUNSELOR PSYCHOLOGIST other

Ever been held back a grade [had to repeat a grade]? N Y If "Y" What grade[s]?: 1 2 3 4 5 6 7 8 9 10 11 12

Best/Easiest/Favorite Subject: Eng Math Science History Govt / Social Studies Art Other:_____

Worst/Hardest/Least Favorite: Eng Math Science History Govt / Social Studies Art Other:_____

In general, <circle> I liked going to school / college I disliked going to school / college neither

EXPLAIN: _____

WORK HISTORY: I am now :<circle> employed unemployed employed, but on [medical] leave Retired

On Disability On SSI/SSD Unemployed but actively looking for work

CURRENT or MOST RECENT JOB: Title or Description:_____

Name of Employer:_____

I began working at this job: _____ [month/year] I Last Worked Here On [give date]: _____

Altogether, I [have] worked here for: _____ years / months I Now / Did Work _____ Hours per week

Held this position: _____ from: _____ to: _____ Hrs/Week: _____

If you are now unemployed [i.e. no longer work at this job], why did you leave?

Laid Off ( ) Moved ( ) Quit ( ) Fired ( ) Retired ( ) Workmen's Compensation ( )

PRIOR JOBS [list the most recent first, the years/months you worked there, your job duties, hrs/week, and mention why you left that job]:

_____

_____

_____

MILITARY SERVICE?: N Y If "Y" complete the following:

Years of Service: from ___/___/____ to ___/___/____ Branch: Army Navy Air Force Marines CG Nat Guard

Discharge Type: <circle> Honorable General Medical/Mental _____ Highest Rank: E - _____ Ever Lost Rank? N Y

Details: _____

Where Did You Serve?: U.S. Europe Germany U.K. Africa Italy Asia Vietnam Thailand Japan Korea

Persian Gulf Somalia Grenada Panama Other:_____ Were You in Combat? N Y

Do You Have a Service Connected Disability? N Y If "Y", complete the following:

What percent [specify each illness] _____% for: _____ _____% for: _____

_____% for: _____ _____% for: _____ _____% for: _____

LEGAL HISTORY: Have you ever been arrested? <circle> NEVER ONCE MORE THAN ONCE

What were you arrested for, when, and how many times? <circle> DUI _____ Disturbing the Peace _____

Assault _____ Robbery _____ Burglary _____ Homicide _____ Spousal Abuse _____

Drug Possession / Sales _____ Forgery _____ Auto Theft _____ Fraud _____ Sexual Offense____

Details: _____

Have you ever done time in jail or prison? <circle> NEVER YES Where, How Long?

Facility: _____ Years / Months: from_____ to _____

Facility: _____ Years / Months: from_____ to _____

Facility: _____ Years / Months: from_____ to _____

Have you ever ***before*** [NOT INCLUDING ANY ONGOING LAWSUIT] been engaged in a lawsuit claiming:

Personal Injury? NO YES Harassment? NO YES Unlawful Termination? NO YES

Please give details about when [what year], what the lawsuit was about, who was involved in the suit, and what the outcome of each lawsuit was: [continue on page 15-16 if needed]

_____

DRIVING HISTORY:

Do you have a valid driver's license? <circle> YES NO

Ever lost your license or had it suspended? <circle> YES NO

If 'YES' specify reason[s]: <circle> speeding DUI too many traffic tickets seizures no insurance

Did you drive yourself here today? <circle> YES NO Are you currently unable to drive? <circle> YES NO

How many motor vehicle [car, truck, motorcycle] accidents have you been involved in the last 10 years?

<circle> none 1 – 2 3 – 4 5 + How many were your fault? <circle> none 1 – 2 3 – 4 5 +

Which is true for you? I always wear seatbelts/helmet I often wear them I rarely or never wear them

If you answered 'rarely' or 'never,' why is this? <circle one>

too uncomfortable/confining too expensive infringes on my personal freedom can't say

HEALTH HISTORY:

My present height is: ____feet __ inches My weight is: ____ lbs. I feel that my ideal o**r 'best' weight** is: ____ lbs.

During the *past 3 to 6 months*, my weight has: <circle> stayed the same increased: ____lbs. decreased: ____lbs.

I believe my weight change was due mainly to: <circle> illness diet change less / inc**reased exercise don't know**

SLEEPING PATTERN: <circle> MOST NIGHTS I SLEEP WELL My sleep problems began: _____

I often can't *get* to sleep I often can't *stay* asleep I often awaken ***too early*, and can't get back to sleep**

I often have bad dreams or repeating dreams about: _____

Do You Have ***Sleep Apnea***? NO YES Have to use CPAP Machine? NO YES [Used to, but not now]

In order to sleep, I must: take pills drink alcohol take a bath meditate none of these

HEART PROBLEMS?: <circle> NONE I ***had*** problems in the past, but not now I ***have current heart problems***

SPECIFY: I have [had]: <circle> heart attack abnormal rhythm mitral valve pacemaker

CABG [Coronary Artery Bypass Graft] Angioplasty [widen heart vessel via inflated catheter]

Other: _____

BLOOD PRESSURE PROBLEMS?: <circle> NONE [no need for medication]

I ***had*** problems in the past, but ***not now*** I ***have current blood pressure problems***

SPECIFY: high blood pressure low blood pressure

fainting spells feel dizzy [light-headed]

my blood pressure is: _____ /over _____ ***without*** medication

my blood pressure is: _____ /over _____ ***with*** medication

My medication for high blood pressure is: _____

STOMACH / INTESTINAL PROBLEMS?: <circle> none ulcers gastritis / gastroenteritis

Acid Reflux chronic diarrhea Crohn's Disease colon cancer irritable bowel

Other: _____

BACK / SPINE PROBLEMS?: <circle> none neck / middle / low back pain slipped disk spinal injury scoliosis

Please give details [when, where, current status]: _____

_____

_____

VISION PROBLEMS? <circle> **none [don't wear glasses or contacts] none [with glasses or contacts]**

I am nearsighted [trouble seeing *distant* objects] farsighted [trouble seeing *close* objects]

I have blurred vision **double vision can't see things off to my right / left**

overly sensitive to light can't see certain colors [Specify: Red Green Blue Yellow]

I have had this problem since: _____

HEARING PROBLEMS? <circle> **none [don't need a hearing aid] none [with my hearing aid]**

I think I have a hearing problem with my <circle> left right both ear[s]

I have had my hearing tested, and I have a loss in my <circle> left right both ear[s]

I have a constant ringing in my <circle> left right both ear[s]

I am overly sensitive to sounds nowadays. Yes ( ) No ( ) How Long? _____

SENSATION CHANGES? <circle> none I have numbness or reduced sensation in these areas: <circle>

LEFT ENTIRE LEFT SIDE or ONLY: FACE SHOULDER HAND UPPER BODY LEG FOOT/TOES

RIGHT ENTIRE RIGHT SIDE or ONLY: FACE SHOULDER HAND UPPER BODY LEG FOOT/TOES

CHANGE IN TASTE / SENSE OF SMELL? <circle> Neither TASTE SMELL Both TASTE and SMELL

SINCE WHEN? <circle> CAN'T SAY Date: Month/Year _____ MY ACCIDENT ILLNESS

EXPOSURE TO: Chemicals Mold Other Substance[s]:) Specify: _____

_____

_____

OTHER ILLNESSES / CONDITIONS? <circle YES or NO for all that apply to YOU or a family member>

HAVE YOU EVER HAD:	Me?	A Family Member?
Allergies [Pollen; Dust, Cats; Foods; Milk; Drugs]	NO YES	NO YES: <circle> brother sister parent grandparent child
Bladder Disease [Chronic infection; Cancer]	NO YES	NO YES: <circle> brother sister parent grandparent child
Bowel Disease [Crohn's; Cancer; Obstruction]	NO YES	NO YES: <circle> brother sister parent grandparent child
Breast Cancer	NO YES	NO YES: <circle> brother sister parent grandparent child
Cardiac Problems: [COPD, CHF, AFib, +/- rate]	NO YES	NO YES: <circle> brother sister parent grandparent child
Circulatory Problems: [hands, legs, feet]	NO YES	NO YES: <circle> brother sister parent grandparent child
Diabetes [high blood sugar]	NO YES	NO YES: <circle> brother sister parent grandparent child
Eating Disorder [Anorexia Nervosa / Bulimia]	NO YES	NO YES: <circle> brother sister parent grandparent child
Epileptic Fits or Seizures	NO YES	NO YES: <circle> brother sister parent grandparent child
Erectile Dysfunction [Impotence] [Men]	NO YES	NO YES: <circle> brother sister parent grandparent child
Sexual Arousal Disorder [Women]	NO YES	NO YES: <circle> brother sister parent grandparent child
HIV Positive Blood Test / AIDS	NO YES	NO YES: <circle> brother sister parent grandparent child
Kidney Disease [Kidney Stones, Kidney Failure]	NO YES	NO YES: <circle> brother sister parent grandparent child
Liver Disease [Cirrhosis, Hepatitis, Jaundice]	NO YES	NO YES: <circle> brother sister parent grandparent child
Lyme Disease [Bitten by a deer tick]	NO YES	NO YES: <circle> brother sister parent grandparent child
Ovarian Cancer [Women]	NO YES	NO YES: <circle> brother sister parent grandparent child
Prostate Cancer [Men]	NO YES	NO YES: <circle> brother sister parent grandparent child
Osteoporosis [Loss of bone density with age]	NO YES	NO YES: <circle> brother sister parent grandparent child
Respiratory Disease [such as: Lung Cancer, Chronic Bronchitis, COPD, Emphysema, Asthma]	NO YES	NO YES: <circle> brother sister parent grandparent child
Stomach Disease [Ulcers; Gastritis; Cancer]	NO YES	NO YES: <circle> brother sister parent grandparent child
Thyroid Disease [Hypo=low Hyper=high]	NO YES	NO YES: <circle> brother sister parent grandparent child

Please explain fully any item where you circled "YES" either for you or a family member: _____

_____

_____

_____

_____

Have you ever been diagnosed with **"**Chronic Fatigue Syndrome**"**? NO YES <explain>

_____

Have you ever been diagnosed with **"Fibromyalgia"**? NO YES <explain>

HEADACHES: Ever suffered from FREQUENT and/or EXTREME headaches **–**i.e. so bad that you went to the doctor and were given a prescription? <circle> N Y If "Y" complete the following:

My headaches are: <circle> MILD and no problem MODERATE and a problem SEVERE and a major problem

They occur: SEVERAL TIMES daily about ONCE a day Once / several times a week several times a month less often Describe: _____

When did these headaches begin? _____ ***What*** Caused Them [if you know]? don't know head injury illness

Explain: _____

Are you EVER headache-free, i.e. are there times w**hen you DON'T have a headache**? N Y

Please rate how painful your headaches have been: <place a letter in the row marked "rating" on the scale below>
Put a " T " where your "TYPICAL" or usual headache pain level is, i.e. when you have a headache.
Put a " L " where the LOWEST LEVEL of headache pain has been, i.e. when you have a headache.
Put a " H " where the HIGHEST LEVEL of headache pain has been, i.e. when you have a headache.

PLACE LETTERS TO SHOW TYPICAL, LOWEST, AND HIGHEST HEADACHE PAIN LEVELS

RATING:									
1	2	3	4	5	6	7	8	9	10
NO PROBLEM	MILDLY PAINFUL		MODERATELY PAINFUL			VERY PAINFUL			UNBEARABLE

What seems to START or PROLONG the headache pain ? <circle> NOTHING loud noise cold air stress, worry bright / flashing / flickering lights certain foods [such as cheese, chocolate] drinks [such as coffee, tea, milk, wine] food additives [such as MSG, Accent, tenderizer] other: _____

What seems to help REDUCE or ELIMINATE the pain? <circle> NOTHING relaxing / resting exercising coffee / tea taking pills [which ones: _____] drinking alcohol herbal medicine other: _____

MEDICATIONS: Please list ALL the drugs / medicines that you are now taking, both prescription drugs and non-prescription drugs [cold remedies, hay fever medications, antacids, aspirin, other pain pills such as Advil, Motrin, Tylenol]

Medication 1: _____ dosage <if you know it>: _____ / day On this drug since: _____
I take this drug for the following problem[s]: DEPRESSION ANXIETY PAIN SLEEP PROBLEMS BLOOD PRESSURE DIABETES SEIZURES

Medication 2: _____ dosage <if you know it>: _____ / day On this drug since: _____
I take this drug for the following problem[s]: DEPRESSION ANXIETY PAIN SLEEP PROBLEMS BLOOD PRESSURE DIABETES SEIZURES

Medication 3: _____ dosage <if you know it>: _____ / day On this drug since: _____
I take this drug for the following problem[s]: DEPRESSION ANXIETY PAIN SLEEP PROBLEMS BLOOD PRESSURE DIABETES SEIZURES

Medication 4: _____ dosage <if you know it>: _____ / day On this drug since: _____
I take this drug for the following problem[s]: DEPRESSION ANXIETY PAIN SLEEP PROBLEMS BLOOD PRESSURE DIABETES SEIZURES

Medication 5: _____ dosage <if you know it>: _____ / day On this drug since: _____
I take this drug for the following problem[s]: DEPRESSION ANXIETY PAIN SLEEP PROBLEMS BLOOD PRESSURE DIABETES SEIZURES

Medication 6: _____ dosage <if you know it>: _____ / day On this drug since: _____

I take this drug for the following problem[s]: DEPRESSION ANXIETY PAIN SLEEP PROBLEMS BLOOD PRESSURE DIABETES SEIZURES

continue on page 16-18 if needed

LIST ANY UNPLEASANT SIDE EFFECTS FOR THESE MEDICATIONS [such as dry mouth, drowsiness, insomnia, etc.]

Medication Number:	Side Effect[s]:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

EVER BROKEN YOUR ARM [WRIST] or LEG [ANKLE]? <circle> N Y RIGHT: arm wrist leg ankle LEFT: arm wrist leg ankle

DO YOU HAVE ANY CONDITION THAT CAUSES PAIN or LIMITS USE OF YOUR ARMS, HANDS OR LEGS? <circle> NO YES specify: _____

EVER HAD MAJOR SURGERY [Where you had to have general anesthesia]? <circle> N Y If 'Y' list each:

START WITH *MOST RECENT*, THEN WORK BACK IN TIME

Date: _____ Type of Surgery: _____ Hospital: _____
Date: _____ Type of Surgery: _____ Hospital: _____
Date: _____ Type of Surgery: _____ Hospital: _____
Date: _____ Type of Surgery: _____ Hospital: _____
Date: _____ Type of Surgery: _____ Hospital: _____
Date: _____ Type of Surgery: _____ Hospital: _____

EVER HAD A BRAIN STUDY ? <circle> N Y These include Electroencephalogram [EEG], Computed Tomography [CT] scan, Magnetic Resonance Imaging [MRI/fMRI] scan, Positron Emission Tomograhic [PET] Scan, and Single Photon Emission Computed Tomography [SPECT] Scan, or Brain Electrical Activity Mapping [BEAM]

Date: _____ Type of Study: _____ Result: Normal Unsure Abnormal
Date: _____ Type of Study: _____ Result: Normal Unsure Abnormal
Date: _____ Type of Study: _____ Result: Normal Unsure Abnormal
Date: _____ Type of Study: _____ Result: Normal Unsure Abnormal

Indicate, if known, what the Abnormal study showed: _____

_____

_____

_____

_____

MENTAL HEALTH HISTORY: <check the statement that applies>

____I have NEVER BEFORE BEEN EVALUATED OR TREATED for a mental or emotional problem [until now]

____I was ***TESTED*** BUT NEVER ***TREATED*** for a mental or emotional problem

Why? _____ When? _____ Where? _____

Who Tested You? _____ Results? ____

_____

_____

____I was ***TREATED*** for a mental or emotional problem for the first time at the age of _____.

Why? <circle> Depression Anxiety PTSD Schizophrenia Bipolar/Manic School Problems

Trouble with the Law Marital Problems Parent/Sibling Problems Work Problems

Other <explain>: _____

When? <estimate the year>_____ Where? _____

Who Treated You? _____ Results? <circle> No change--Some Improv--Signif Improv

Type of treatment: <circle> Individual [one-to-one] Couples Family Group Medications? NO YES

How Often Were Your Appointments? <circle> twice a week weekly every 2 weeks 3-4 times/month]

Varied Schedule: At first weekly, then every 2 - 3 weeks or so Appointments were irregular

Later Treatment[s]: <estimate the year; identify the main problem[s], and the person/place providing treatment>

Year[s]: _____ Problem[s]: _____ Provider: _____

Year[s]: _____ Problem[s]: _____ Provider: _____

Year[s]: _____ Problem[s]: _____ Provider: _____

Year[s]: _____ Problem[s]: _____ Provider: _____

Year[s]: _____ Problem[s]: _____ Provider: _____

Are you currently in treatment for a mental health problem? NO YES If YES:

Name of Therapist: _____ Total Visits to Date: _____ [Approx.]

Frequency of visits: Twice a Week Weekly Every 2 weeks Monthly Every other month

Type of Treatment: Individual [1 to 1] Group Couples Family [Parents and children] Medications

<list others and give details on Page 15-16 >

Have you ever THOUGHT SERIOUSLY ABOUT, PLANNED, or ATTEMPTED suicide? <circle> N Y

Reasons> _____

List Plans or Attempts:

Year _____ Method: Firearm Jump Overdose Cut Wrist[s] Crash Car Other:_____

Year _____ Method: Firearm Jump Overdose Cut Wrist[s] Crash Car Other:_____

Year _____ Method: Firearm Jump Overdose Cut Wrist[s] Crash Car Other:_____

Do you currently find yourself thinking very angry thoughts or feeling very angry toward a certain person?

<circle> No Yes Who? Spouse Parent Child Other relative: _____ Ex-Wife/Husband

Boss Co-Worker Neighbor Police Jail Guard[s] <list others and give details on Page 15-16 >

Do you own / have access to firearms [pistol, rifle, shotgun]? NO YES If "YES," circle each firearm, then indicate how long you've owned it, and what it is used for:

Firearm 1: Handgun/Pistol Rifle Shotgun Had for: _____ Used For: _____

Firearm 2: Handgun/Pistol Rifle Shotgun Had for: _____ Used For: _____

Others: _____

NEUROPSYCHOLOGICAL HISTORY: Please complete the following as best you can:

HAVE YOU EVER HAD A HEAD INJURY? <circle> YES NO [If you answered "NO" skip to page 15]

By "Head Injury" we mean an injury in which you either hit your head on something, something hit you on the head, or you experienced such a severe 'whiplash' injury that you were dazed, confused, or unconscious.

FILL IN AS MUCH DETAIL AS YOU CAN FOR EACH INJURY [start with the most recent one and work back from there]

#1 MOST RECENT INJURY:

Date: _____ Cause: <circle> VEHICLE CRASH | HIT ON HEAD | FELL | FIGHTING/ASSAULT | BULLET/SHRAPNEL | SURGERY |

Unconscious?: NO YES, for: <circle your best estimate, based on what you know or have learned>

5 – 60 secs	1 - 5 mins	5 -10 mins	10 -20 mins	20-30 mins	30 -60 mins	1 - 2 hours	2 - 8 hours	8 - 24 hours	1 - 2 days	2 - 6 days	7 - 14 days	2 - 4 weeks	more than 4 weeks

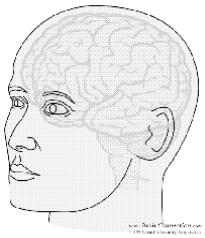
Was there a period after your accident when you were really confused and couldn't recognize family members or friends, were unsure of where you were, or had trouble remembering ongoing events?
NO YES for an estimated: <circle your best estimate, based on what you know or have learned>

less than 1 hour	1 - 4 hours	4 – 8 hours	8 – 12 hours	12-24 hours	1 – 2 days	2 - 7 days	1 - 2 weeks	2 – 4 weeks	1 – 3 months	3 – 6 months	6 – 12 months	more than 1 year

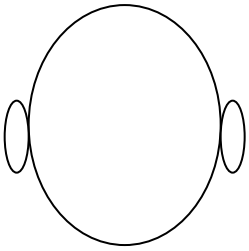
Describe the injury / accident: _____

_____

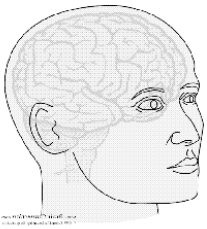
USE THE DRAWINGS BELOW TO SHOW WHERE YOUR HEAD WAS INJURED. MARK ✕ or DRAW AN ARROW TO INDICATE



LEFT SIDE of HEAD



BACK of HEAD



RIGHT SIDE of HEAD

#2 OTHER INJURY:

Date: _____ Cause: <circle> VEHICLE CRASH | HIT ON HEAD | FELL | FIGHTING/ASSAULT | BULLET/SHRAPNEL | SURGERY |

Unconscious?: NO YES, for: <circle your best estimate, based on what you know or have learned>

5 – 60 secs	1 - 5 mins	5 -10 mins	10 -20 mins	20-30 mins	30 -60 mins	1 - 2 hours	2 - 8 hours	8 - 24 hours	1 - 2 days	2 - 6 days	7 - 14 days	2 - 4 weeks	more than 4 weeks

Was there a period after your accident when you were really confused and couldn't recognize family members or friends, were unsure of where you were, or had trouble remembering ongoing events?
NO YES for an estimated: <circle your best estimate, based on what you know or have learned>

less than 1 hour	1 - 4 hours	4 – 8 hours	8 – 12 hours	12-24 hours	1 – 2 days	2 - 7 days	1 - 2 weeks	2 – 4 weeks	1 – 3 months	3 – 6 months	6 – 12 months	more than 1 year

Describe the injury / accident: _____

_____

#3 OTHER INJURY:

Date: _____ Cause: <circle> VEHICLE CRASH | HIT ON HEAD | FELL | FIGHTING/ASSAULT | BULLET/SHRAPNEL | SURGERY |

Unconscious?: NO YES, for: <circle your best estimate, based on what you know or have learned>

5 – 60 secs	1 - 5 mins	5 -10 mins	10 -20 mins	20-30 mins	30 -60 mins	1 - 2 hours	2 - 8 hours	8 - 24 hours	1 - 2 days	2 - 6 days	7 - 14 days	2 - 4 weeks	more than 4 weeks

Was there a period after your accident when you were really confused and couldn't recognize family members or friends, were unsure of where you were, or had trouble remembering ongoing events?
NO YES for an estimated: <circle your best estimate, based on what you know or have learned>

less than 1 hour	1 - 4 hours	4 – 8 hours	8 – 12 hours	12-24 hours	1 – 2 days	2 - 7 days	1 - 2 weeks	2 – 4 weeks	1 – 3 months	3 – 6 months	6 – 12 months	more than 1 year

Describe the injury / accident: _____

_____

#4 OTHER INJURY:

Date: _____ Cause: <circle> VEHICLE CRASH | HIT ON HEAD | FELL | FIGHTING/ASSAULT | BULLET/SHRAPNEL | SURGERY |

Unconscious?: NO YES, for: <circle your best estimate, based on what you know or have learned>

5 – 60 secs	1 - 5 mins	5 -10 mins	10 -20 mins	20-30 mins	30 -60 mins	1 - 2 hours	2 - 8 hours	8 - 24 hours	1 - 2 days	2 - 7 days	7 - 14 days	2 - 4 weeks	more than 4 weeks

Was there a period after your accident when you were really confused and couldn't recognize family members or friends, were unsure of where you were, or had trouble remembering ongoing events?
NO YES for an estimated: <circle your best estimate, based on what you know or have learned>

less than 1 hour	1 - 4 hours	4 – 8 hours	8 – 12 hours	12-24 hours	1 – 2 days	2 - 7 days	1 - 2 weeks	2 – 4 weeks	1 – 3 months	3 – 6 months	6 – 12 months	more than 1 year

Describe the injury / accident: _____

_____

#5 OTHER INJURY:

Date: _____ Cause: <circle> VEHICLE CRASH | HIT ON HEAD | FELL | FIGHTING/ASSAULT | BULLET/SHRAPNEL | SURGERY |

Unconscious?: NO YES, for: <circle your best estimate, based on what you know or have learned>

5 – 60 secs	1 - 5 mins	5 -10 mins	10 -20 mins	20-30 mins	30 -60 mins	1 - 2 hours	2 - 8 hours	8 - 24 hours	1 - 2 days	2 - 7 days	7 - 14 days	2 - 4 weeks	more than 4 weeks

Was there a period after your accident when you were really confused **and couldn't recognize family** members or friends, were unsure of where you were, or had trouble remembering ongoing events?
NO YES for an estimated: <circle your best estimate, based on what you know or have learned>

less than 1 hour	1 - 4 hours	4 – 8 hours	8 – 12 hours	12-24 hours	1 – 2 days	2 - 7 days	1 - 2 weeks	2 – 4 weeks	1 – 3 months	3 – 6 months	6 – 12 months	more than 1 year

Describe the injury / accident: _____

_____

DETAILS ON ANY ADDITIONAL HEAD INJURIES, PLEASE USE THE CONTINUATION PAGE [Page 16-18]

OTHER CONDITIONS OF INTEREST:

CHECK √ ANY THAT ARE TRUE FOR YOU:

__**STROKE or "CVA"**

Date:_____ Type [If you know]: Hemorrhage Aneurysm Embolism Thrombosis Ischemia
AV Malformation What, if any, was your Weak Side? <circle>: L R

Date:_____ Type [If you know]: Hemorrhage Aneurysm Embolism Thrombosis Ischemia
AV Malformation What, if any, was your Weak Side? <circle>: L R

Date:_____ Type [If you know]: Hemorrhage Aneurysm Embolism Thrombosis Ischemia
AV Malformation What, if any, was your Weak Side? <circle>: L R

Notes: _____

__BRAIN INFECTION

Date:_____ Type [If you know]: Meningitis HIV Lupus [Herpes] Encephalitis Brain Cyst
Notes:_____

Date:_____ Type [If you know]: Meningitis HIV Lupus [Herpes] Encephalitis Brain Cyst
Notes:_____

__ OTHER EXTREMELY HIGH FEVER [over 103^0 F or 39^0 C]

Date:_____ Type [If you know]: Rheumatic F. Scarlet F. Measles Mumps Malaria UNKNOWN
Notes:_____

Date:_____ Type [If you know]: Rheumatic F. Scarlet F. Measles Mumps Malaria UNKNOWN
Notes:_____

__ BRAIN TUMOR or **"BRAIN CANCER"**

Date[s]:_____ Type: Glioma gr I II III IV Meningioma Adenoma Other:_____
Location: LF LT LP LO --- MIDLINE --- RF RT RP RO BrainStem Olfactory Groove
Notes:_____

__ **PARKINSON'S DISEASE**

Date[s]:_____

Symptoms / Signs: Rigidity Trouble Walking Reduced Arm Swing Reduced Facial Expression

Notes:_____

OTHER CONDITION: <specify> _____

SUBSTANCE USE HISTORY: [Gray sections refer to PAST substance use]

HAVE YOU EVER BEEN A REGULAR DRINKER [OF ALCOHOL]? YES NO

HAVE YOU EVER BEEN A REGULAR USER of STREET DRUGS? YES NO [if "NO" to both, skip this page]

ALCOHOL: Circle the description that fits you best [CURRENTLY]: <circle>

I drink very rarely [or never] I drink 1 to 2 times a month I drink about once a week
I drink 2 to 5 times a week I drink just about every day I drink wine with meals
I drink several drinks each day I drink till I get drunk I feel I have an alcohol problem

Circle the description that fits you best [PAST]: Pretty much the same as now

I drank very rarely [or never] I drank now and then: 1 to 2 times a month I drank about once a week

I drank 2 to 5 times a week I drank just about every day I drank several drinks each day

NOTES: _____

When you drink [NOW], HOW MUCH do you usually drink? <circle> 1 [drink/glass/can] 2 -4 5-6 7 or more

When you drank [PAST], HOW MUCH did you usually drink? <circle> 1 [drink/glass/can] 2-4 5-6 7 or more

WHAT do you usually drink]? <circle> beer wine brandy/cognac whiskey vodka gin rum tequila

mixed drinks [martinis / manhattans / whiskey sours / gin or vodka tonic] shots other_____

Has your drinking ever a problem in the following areas? <circle> marriage/home work military school

DUI Medical Conditions [such as Cirrhosis of the Liver Peripheral Neuropathy Seizures]

If you circled any of these areas, please give details [when, where, how, how many times]

_____

Have you ever been in a Treatment Program for Alcohol Problems? N Y Give details [when, where, how long]

DRUGS: Choose the description that fits you best [CURRENTLY]: <circle>

I am NOT a regular user of any recreational drugs now, but at a younger age I experimented with drugs

I NOW USE marijuana RARELY [but not other drugs such as cocaine, crack, heroin, or speed]

I NOW USE marijuana MORE THAN 4 TIMES A MONTH I USE ONE OR MORE DRUGS at least once a week

[including cocaine, crack, heroin, or speed] I am a REGULAR-TO-HEAVY drug user; I feel I have a drug problem

I am ADDICTED TO ONE OR MORE DRUGS [including cocaine, crack, heroin, or speed] <circle drugs below>

Circle the description that fits you best [PAST]: I TRIED certain drugs, but was NEVER A REGULAR USER

I used drugs ON OCCASION over months/years I used drugs AT LEAST ONCE A WEEK for months / years
I was a REGULAR-TO-HEAVY drug user <circle below> I was ADDICTED to one or more drugs <circle below>

marijuana **cocaine [inhaled/injected]** **"crack" [smoke**d] heroin opium methamphetamine or speed LSD
Ecstasy prescription drugs: Quaalude Valium Phenobarbital Percodan Demerol Dilaudid
other: [specify]_____
Solvents / chemicals: gasoline glue paint thinner nitrous oxide Other: [specify]_____
If you have a Drug Habit [or *had* one] how much do / did you use each day? ____ Est. cost per day: $ __/day
Was your drug use ever a problem in these areas? <circle> relationships work military school arrest
If you circled any of these areas, please give details [when, where, how, how many times]
Were you ever in Treatment Program for Drug Problems? N Y Give details [when, where, how long]

_____

OTHER SUBSTANCE USE: Are you a cigarette / cigar smoker? <circle> NO, NEVER SMOKED NO, I QUIT IN _____
YES: I smoke _____ Packs or Cigars /day ; I [HAVE] SMOKED FOR A TOTAL OF ____ YEARS
I have had health problems due to smoking: <circle> lung disease heart disease blood pressure
I am trying to cut down or quit I am a heavy smoker, and proud of it [will never quit]

MAIN LIMITATIONS PREVENTING RETURN TO WORK / SCHOOL / NORMAL LIVING: <If you have no such problems, please circle "Not Applicable" and skip to the next page> Not Applicable

MEMORY PROBLEMS: On a scale of 1 to 10, with 1 meaning NONE, and 10 being SEVERE (i.e. maximum memory impairment), rate your memory as it was BEFORE (***pre***) and is NOW (***since*** your accident, illness, hospitalization, surgery, treatment, event: <CIRCLE ONE NUMBER IN EACH ROW TO INDICATE YOUR RATING>
IF YOU DON'T KNOW OF ANYTHING IN THE PAST THAT MIGHT HAVE CAUSED PROBLEMS IN THE FOLLOWING AREAS, JUST RATE YOURSELF IN THE "NOW" CATEGORIES FOR EACH PROBLEM.
Definitions of Memory Types:

***IMMEDIATE** MEMORY*: RECALLING PHONE #'S, DIRECTIONS, PEOPLE'S NAMES, WHAT JUST HAPPENED
***RECENT** MEMORY*: RECALLING RECENT EVENTS, NEWS, ASSIGNMENTS, APPOINTMENTS
***REMOTE** MEMORY:* RECALLING YOUR BIRTHDATE, BIRTHPLACE, CHILDHOOD, KEY HISTORICAL EVENTS

MEMORY TYPE:	NONE	SLIGHT		MILD		MODERATE		MARKED		SEVERE
IMMEDIATE BEFORE	1	2	3	4	5	6	7	8	9	10
IMMEDIATE NOW	1	2	3	4	5	6	7	8	9	10
RECENT BEFORE	1	2	3	4	5	6	7	8	9	10
RECENT NOW	1	2	3	4	5	6	7	8	9	10
REMOTE BEFORE	1	2	3	4	5	6	7	8	9	10
REMOTE NOW	1	2	3	4	5	6	7	8	9	10

PAIN PROBLEMS: On a scale of 1 to 10, with 1 meaning NONE, and 10 being SEVERE (i.e. maximum pain), rate your pain as it was BEFORE and is NOW (since the accident or event): <CIRCLE ONE NUMBER IN EACH ROW TO INDICATE YOUR RATING>

PAIN PROBLEM:	NONE	SLIGHT		MILD		MODERATE		MARKED		SEVERE
HEADACHES BEFORE	1	2	3	4	5	6	7	8	9	10
HEADACHES NOW	1	2	3	4	5	6	7	8	9	10

BACKACHES BEFORE	1	2	3	4	5	6	7	8	9	10
BACKACHES NOW	1	2	3	4	5	6	7	8	9	10

OTHER PAIN BEFORE	1	2	3	4	5	6	7	8	9	10
OTHER PAIN NOW	1	2	3	4	5	6	7	8	9	10

SPEECH / LANGUAGE PROBLEMS: On a scale of 1 to 10, with 1 meaning NONE, and 10 being SEVERE (i.e. MAJOR or CONSTANT) problems, rate your speech / language as it was BEFORE and is NOW (since the accident or event): <CIRCLE ONE NUMBER IN EACH ROW TO INDICATE YOUR RATING>

PROBLEM AREA:	NONE	SLIGHT		MILD		MODERATE		MARKED		SEVERE
SPEAKING BEFORE	1	2	3	4	5	6	7	8	9	10
SPEAKING NOW	1	2	3	4	5	6	7	8	9	10

READING BEFORE	1	2	3	4	5	6	7	8	9	10
READING NOW	1	2	3	4	5	6	7	8	9	10

WRITING BEFORE	1	2	3	4	5	6	7	8	9	10
WRITING NOW	1	2	3	4	5	6	7	8	9	10

LISTENING BEFORE	1	2	3	4	5	6	7	8	9	10
LISTENING NOW	1	2	3	4	5	6	7	8	9	10

CONTINUATION PAGE: You may add anything else that you feel is important about your present condition; or use this page to explain previous items more completely.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ ___/___/___

Signature *Date*

Note: If you are completing this form for the patient, please sign and date below:

_____

Print Name

_____ ___/___/___

Signature of Person Completing Form *Date*

_____

Relationship to Patient