NEUROBEHAVIORAL LABORATORY INFORMATION FORM

Name: _____ Date of Birth:_____ Age: _____

Handedness: Right _____ Left_____ Mixed_____ Education Level (Highest grade or degree completed): _____

Are you presently involved in any legal action relating to your current complaints? (ie: law suits related to personal injury or malpractice) IF YES, BE SURE THE SCHEDULER IS AWARE PRIOR TO ARRIVING TO YOUR APPOINTMENT!

_____

_____

Are you presently involved in any Worker's Compensation claim relating to your current complaints? IF YES, BE SURE THE SCHEDULER IS AWARE PRIOR TO ARRIVING TO YOUR APPOINTMENT!

_____

_____

Describe the problems that lead to the current referral.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have others commented to you about changes in your thinking, behavior, personality or mood? If YES, please describe (who and what did they say?). If NO, please SKIP this box.

_____

_____

_____

_____

Are you experiencing any problems in the following aspects of your life?

Marital/Family:_____

Financial/Legal:_____

Housekeeping/Money Management: _____

Driving: _____

Please indicate if you are presently having any of the following concerns:

Please check on the line, if yes	**Comments:**
_____**Difficulty figuring out how do new things**	_____
_____**Difficulty thinking as quickly as needed**	_____
_____**Difficulty doing things in the right order (sequencing)**	_____
_____**Difficulty finding the right word**	_____
_____**Slurred Speech**	_____
_____**Difficulty expressing thoughts**	_____
_____**Difficulty understanding what others say**	_____
_____**Difficulty understanding what I read**	_____
_____**Difficulty writing letters or words (not due to motor problems)**	_____
_____**Difficulty with math (ie: balancing checkbook, making change)**	_____
_____**Difficulty telling right from left**	_____
_____**Difficulty drawing or copying**	_____
_____**Difficulty dressing (not due to motor problems**	_____
_____**Problems finding way around familiar places**	_____
_____**Difficulty recognizing objects or people**	_____
_____**Parts of my body do not seem as if they belong to me**	_____
_____**Not aware of time (ie: day, season, year)**	_____
_____**Highly distractible**	_____
_____**Lose my train of thought easily**	_____
_____**Difficulty doing more than one thing at a time**	_____
_____**Become easily confused and disoriented**	_____
_____**Aura (strange feeling)**	_____
_____**Don't feel alert or aware of things**	_____
_____**Tasks require more effort or attention**	_____
_____**Forget where I leave things (ie: keys, gloves, etc)**	_____
_____**Forget names**	_____
_____**Forget where I am or where I am going**	_____
_____**Forget recent events (ie:, breakfast)**	_____
_____**Forget appointments or events that happened long ago**	_____
_____**More reliant on notes or other people to remind me of things**	_____

Are you followed or being treated for any medical or neurological problem?

Yes: _____ No: _____ ***If yes, please list:***

_____

_____

_____

Have you ever been hospitalized or required surgery? If yes, explain: (give approximate dates if possible)

_____

_____

_____

Have you ever had a head injury? If NO you can SKIP this section:

<u>If Yes,</u> When? _____

Did you lose consciousness? YES NO DON'T KNOW

For how long _____hours _____days ____ minutes

Were you hospitalized? YES NO DON'T KNOW
For how long _____hours _____days
Were you different or did you have any problems after your injury? YES NO DON'T KNOW

If yes, describe the difference or problem:_____

_____

_____

Has any family member been diagnosed with a neurological illness (e.g. stroke, Parkinson's Disease, Huntington's Disease, Multiple Sclerosis, Downs Syndrome, etc.) or DEMENTIA (e.g. Alzheimer's disease, Vascular dementia, Lewy Body dementia, Frontotemporal dementia)? (Circle One)

YES NO DON'T KNOW

If yes, explain:

_____

_____

_____

_____

Please indicate if <u>you</u> ever had or presently have any of the following conditions:

	Circle	Year Diagnosed	Comments:
High Blood Pressure	**YES / NO**	_____	_____
High Cholesterol	**YES / NO**	_____	_____
Cancer	**YES / NO**	_____	_____
Stroke	**YES / NO**	_____	_____
Brain Tumor	**YES / NO**	_____	_____
Seizures	**YES / NO**	_____	_____
Neurologic Illness	**YES / NO**	_____	_____
Sleep Apnea	**YES / NO**	_____	_____
Heart Attack	**YES / NO**	_____	_____
Diabetes	**YES / NO**	_____	_____
Thyroid Problems	**YES / NO**	_____	_____
Migraines	**YES / NO**	_____	_____
Unintentional Weight gain	**YES / NO**	_____	_____
Dizziness	**YES / NO**	_____	_____
Excessive Fatigue	**YES / NO**	_____	_____
Urinary Incontinence	**YES / NO**	_____	_____
Muscle Weakness	**YES / NO**	_____	_____
Tremor (indicate body part)	**YES / NO**	_____	_____
Balance Problems	**YES / NO**	_____	_____
Blackout Spells (fainting)	**YES / NO**	_____	_____
Numbness/Tingling (indicate where)	**YES / NO**	_____	_____
Light Sensitivity	**YES / NO**	_____	_____
Vision problems/Changes	**YES / NO**	_____	_____
Hearing problems/Changes	**YES / NO**	_____	_____

Please List your medications: (If you have a list, please write "see attached" and provide the list)

Name of drug or supplement:	**Dose**	**Frequency:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever seen a psychiatrist, psychologist, counselor, or other psychotherapist for assistance with personal or emotional problems? If YES, please provide a brief explanation. If NO, you can skip this box.

_____

_____

_____

Have you ever been hospitalized for personal or emotional problems? If Yes, please List:

_____

_____

Have you experienced perceptual disturbances such as seeing or hearing things that were actually not real? If yes, please explain: _____

_____

Has anyone in your family ever had psychiatric (mental or emotional) or cognitive (memory loss) problems? If YES, check below the relative or relatives who had these difficulties. If NO, you can skip this box.

	Psychiatric	Memory Loss
Mother	_____	_____
Father	_____	_____
Sister	_____	_____
Brother	_____	_____
Other Relative	_____	_____

Has anyone in your family been hospitalized for mental illness? If YES, check which relative or relatives were hospitalized. If NO, you can SKIP this box.

_____ Mother _____ Father _____ Sister _____ Brother _____ Other Relative

Which best describes the illness or illnesses for which your relative(s) required treatment?

_____ Depression
_____ Anxiety
_____ Schizophrenia (Strange thoughts, unusual behavior, hearing things)
_____ Manic Behavior
_____ Alcohol or Drug Problems
_____ Sexual Problems
_____ Dementia (behavior change, memory loss, confusion)
_____ Other problems
_____ Not sure

Have you, or Has anyone in your family committed or attempted suicide. If YES, please check the appropriate line. If NO, you can SKIP this box.

_____Self
_____Mother
_____Father
_____Sister
_____ Brother
_____Other Relative

How would you describe your <u>current overall</u> mood?

_____

_____

_____

How Long does it take you to fall asleep? _____

Once asleep, do you stay asleep? _____

On average, how many hours do you sleep at night? _____

Do you nap during the day? _____

Do you thrash about in bed while dreaming? _____

How would you describe your daytime energy level? _____

How is your appetite and has there been any change? _____

Has there been a recent change in your weight? _____

Has there been a change in your sense of smell? _____

Do you now or did you ever use alcohol? If "Yes" please answer the below questions. If "NO" you can SKIP to the last question in this box.

Amount and frequency of your <u>current</u> use? drinks per: _____week _____ month _____ year
Amount and frequency of your <u>previous</u> use? drinks per: _____week _____ month _____ year

Have you ever felt you ought to cut down on your drinking?	**YES**	**NO**
Have people annoyed you by criticizing your drinking?	**YES**	**NO**
Have you ever felt guilty about your drinking?	**YES**	**NO**
Have you ever had a drink first thing in the morning to steady Your nerves or get rid of a hangover?	**YES**	**NO**

Have you had legal problems due to alcohol use such as being cited for driving while intoxicated? If "Yes" describe:

_____

_____

_____

Has anyone in your family ever had a drinking problem? If YES, check below the relative or relatives who had this problem.
_____ Mother _____ Father _____ Sister _____ Brother _____ Other Relative

Do you now or did you ever use "street drugs" or prescribed narcotic medications? If "Yes" please answer the below questions. If "NO" you can SKIP to the last question in this box.

Name of drug(s): _____
Amount and frequency of your <u>current</u> use? per: _____week _____ month _____ year
Amount and frequency of your <u>previous</u> use? per: _____week _____ month _____ year

Have you ever felt you depended too much on taking the drug?	**YES**	**NO**
Has drug use ever interfered with your ability to do your job?	**YES**	**NO**
Has drug use ever interfered with your home or family life?	**YES**	**NO**
Have you ever felt that you shouldn't use drugs but found It hard to stop?	**YES**	**NO**

Have you had legal problems due to drug use such as being cited for driving while under the influence? If "Yes" describe:

_____

_____

_____

Has anyone in your family ever had a drug problem? If YES, check below the relative or relatives who had this problem.
_____ Mother _____ Father _____ Sister _____ Brother _____ Other Relative

How well did you do in elementary and middle school? (Grades 1-8) (Circle One)
Superior Above Average Average Below Average Failing

What were your best subjects? _____

What were your worst subjects? _____

Did you have to repeat a grade? _____

Did you receive any form of special instructions? (ie: tutoring, remedial or special education classes)

_____

Did you experience behavior problems in school resulting in being disciplined? (ie: suspended, expelled)

_____

How well did you do in High School? (Grades 9-12) (Circle One)
Superior Above Average Average Below Average Failing

What were your best subjects? _____

What were your worst subjects? _____

Did you have to repeat a grade? _____

Did you receive any form of special instructions? (ie: tutoring, remedial or special education classes)

_____

Did you experience behavior problems in school resulting in being disciplined? (ie: suspended, expelled)

_____

How well did you do in College? (If you did not attend college, please SKIP) (Circle One)
Superior Above Average Average Below Average Failing

What were your best subjects? _____

What were your worst subjects? _____

Type of Degree(s) earned? (ie: GED, A.A., B.A, M.A, Ph.D, etc) _____

Describe any specialized training you have completed: _____

_____

Please describe any factors which may have prevented you from receiving a normal level of education: (ie: family moving around frequently, extended and/or frequent absences from school, behavioral issues) Please be specific:
_____

_____

During *childhood/adolescence* have you ever suffered from: (use your own judgement, regardless whether or not these were ever diagnosed)

Significant Reading Problems	**YES**	**NO**	**DON'T KNOW**
Math Problems	**YES**	**NO**	**DON'T KNOW**
Stuttering	**YES**	**NO**	**DON'T KNOW**
Withdrawing from other Children	**YES**	**NO**	**DON'T KNOW**
Late acquiring speech (after age 3)	**YES**	**NO**	**DON'T KNOW**
Learning problems	**YES**	**NO**	**DON'T KNOW**
Childhood Attention Problems	**YES**	**NO**	**DON'T KNOW**

If you circled "YES" to any of the above, please explain: _____

_____

Please indicate the highest level of education completed by your:

Mother: _____ Father:_____

Please indicate the occupation of your:

Mother: _____ Father: _____

Please indicate your marital status:

_____Married
_____ Domestic Partner
_____Single
_____Divorced
_____Widowed
_____Separated

With whom do you live? _____

Do you have Children? If yes, please give their gender and ages:

_____

_____

Where were you born and raised? _____

Primary Languages spoke in the home: _____
What Languages do you speak? _____

Please list your jobs (starting with the most recent and working backwards) If you have a resume, you may attach it.

Job title_____ years at this job:____19_____-19____

Describe your job duties: _____

_____

Job title_____ years at this job:____19_____-19____

Describe your job duties: _____

_____

Job title_____ years at this job:____19_____-19____

Describe your job duties: _____

_____

Job title_____ years at this job:____19_____-19____

Describe your job duties: _____

_____

Have there been any problems at jobs that you believe are related to cognitive, memory or attention problems? If YES, please describe. If NO, please SKIP this box.

_____

_____

_____

_____

Did you serve in the military? If YES, please answer the below questions. If NO, please SKIP this box.

What branch? _____Date(s) of service: _____

Certifications/Duties:_____

_____

Rank when retired: _____Did you serve during war time? _____

Did you receive injuries or were you ever exposed to any dangerous or unusual stubstances during your service?

_____

_____