

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:

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

If Yes, 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 you 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 current overall 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 current use? drinks per: _____ week _____ month _____ year

Amount and frequency of your previous 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 current use? per: _____ week _____ month _____ year

Amount and frequency of your previous 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 substances during your service?
