NEUROBEHAVIORAL LABORATORY FORM

Name: _____ Date of Birth: _____ Age: _____

Handedness: ☐ Right ☐ Left ☐ Ambidextrous **Education Level (Highest grade or degree completed): _____**
Sex assigned at birth: ☐ Male ☐ Female
Gender Identity: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Another Identity _____
My Pronouns: ☐ He/Him/His ☐She/Her/Hers ☐They/Them/Theirs ☐Another Pronoun _____

Are you presently involved in any legal action relating to your current complaints? (i.e., lawsuits 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: _____

Safety Concerns: _____

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

Please check if YES **Comments:**

- ☐ Difficulty figuring out how to 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 (i.e., 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 (i.e., 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 (i.e., keys, gloves, etc.) _____
- ☐ Forget names _____
- ☐ Forget where I am or where I am going _____
- ☐ Forget recent events (i.e., 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? ☐ **Yes** ☐ **No**
If yes, explain and 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 _____ minutes
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, Down Syndrome, etc.) or DEMENTIA (e.g., Alzheimer's disease, Vascular dementia, Lewy Body dementia, Frontotemporal dementia)?
☐ **YES** ☐ **NO** ☐ **DON'T KNOW**
If yes, explain:

Please indicate if YOU ever had or presently have any of the following conditions:

	Indicate		*Year Diagnosed*	*Comments:*
High Blood Pressure	☐ YES	☐ NO		
High Cholesterol	☐ YES	☐ NO		
Cancer	☐ YES	☐ NO		
Stroke	☐ YES	☐ NO		
Seizures	☐ YES	☐ NO		
Brain Tumor	☐ 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		
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(s) who had these difficulties. If NO, you can skip this box.

	Psychiatric	Memory Loss	
Mother	☐	☐	
Father	☐	☐	
Sister	☐	☐	
Brother	☐	☐	
Other Relative	☐	☐	Specify: _____

Has anyone in your family been hospitalized for mental illness?
If YES, check which relative(s) were hospitalized. If NO, you can SKIP this box.
☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Other Relative (Specify):

Which best describes the illness(es) for which your relative(s) required treatment
☐ Depression
☐ Anxiety
☐ Schizophrenia (i.e., strange thoughts, unusual behavior, hearing things)
☐ Manic Behavior
☐ Alcohol or Drug Problems
☐ Sexual Problems
☐ Dementia (i.e., 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 ☐ Sister
☐ Mother ☐ Brother
☐ Father ☐ 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? ☐ YES ☐ NO

How many days <u>per week</u> do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the highest number of drinks you will drink in a day? _____

In the past three (3) months, what is the largest amount of alcohol you consumed in one day? _____

Have you ever used, or do you currently use any of the following (other than as prescribed)?

			Explain (incl. first use, frequency, amount, last use)
Marijuana	☐ YES	☐ NO	
Cocaine	☐ YES	☐ NO	
Other Stimulants *(amphetamines, methamphetamines, Adderall, Ritalin, etc.)*	☐ YES	☐ NO	
Heroin	☐ YES	☐ NO	
Other Opiates *(Oxycodone, hydrocodone, morphine, codeine, etc.)*	☐ YES	☐ NO	
Depressants/Sedatives *(Benzos, Xanax, barbiturates, etc.)*	☐ YES	☐ NO	
Hallucinogens *(PCP, LSD/acid, mushrooms, Ecstasy, Ketamine, etc.)*	☐ YES	☐ NO	
Inhalants *(Whippets, paint thinner, glue, etc.)*	☐ YES	☐ NO	
Other (specify): _____	☐ YES	☐ NO	

Have you ever felt you ought to cut down on your drinking or drug use? ☐ YES ☐ NO

Have people annoyed you by criticizing your drinking or drug use? ☐ YES ☐ NO

Have you ever felt bad/guilty about your drinking or drug use? ☐ YES ☐ NO

Have you had a drink/used drugs first thing in the morning to steady your nerves? ☐ YES ☐ NO

Has your drinking or drug use ever interfered with your ability to do your job? ☐ YES ☐ NO

Has your drinking or drug use ever interfered with your home or family life? ☐ YES ☐ NO

Have you ever been treated for alcohol or drug use/abuse? ☐ YES ☐ NO

If yes, for which substances? _____

If yes, where were you treated and when? _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Have you ever used tobacco? ☐ YES ☐ NO

What have you used: □ Cigarettes □ Cigars □ Pipe □ Chewing Tobacco □ Vaping □ Other

Do you currently use tobacco? ☐ YES ☐ NO

If yes, How often per day on average? _____ How many years have you been using? _____

If no, When did you quit? _____ How many years did you use nicotine? _____

Have you had legal problems due to alcohol or drug 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 (Specify): _____

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 (Specify):_____

How well did you do in elementary and middle school? (Grades 1-8) (Indicate 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? (i.e., tutoring, remedial, or special education classes)

Did you experience behavior problems in school resulting in being disciplined? (i.e., suspended, expelled)

How well did you do in High School? (Grades 9-12) (Indicate 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? (i.e., tutoring, remedial, or special education classes)

Did you experience behavior problems in school resulting in being disciplined? (i.e., suspended, expelled)

How well did you do in College? (If you did not attend college, please SKIP) (Indicate One)

☐ Superior ☐ Above Average ☐ Average ☐ Below Average ☐ Failing

What were your best subjects? _____

What were your worst subjects? _____

Type of Degree(s) earned? (i.e., 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 (i.e., family moving around frequently, extended and/or frequent absences from school, behavioral issues):

During *childhood/adolescence* have you ever suffered from: *(Use your own judgement, regardless of 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 spoken in the home: _____

What languages do you speak? _____

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

Job title: _____ Years at this job: _____ Dates: _____ - _____
Describe your job duties:

Job title: _____ Years at this job: _____ Dates: _____ - _____
Describe your job duties:

Job title: _____ Years at this job: _____ Dates: _____ - _____
Describe your job duties:

Job title: _____ Years at this job: _____ Dates: _____ - _____
Describe your job duties:

Have there been any problems at job(s) 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? ☐ YES ☐ NO
Did you receive injuries or were you ever exposed to any dangerous or unusual substances during your service?