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NEUROPSYCHOLOGY PATIENT HISTORY FORM
CONFIDENDTIAL

Demographics

Patient's Name	**Patient's Date of Birth**	**Patient's Gender** ☐ Female ☐ Male ☐ Other: _____
Patient's Address:		
Phone #:		
Email address:		
Patient's Race/Ethnicity ☐ African American/Black ☐ Asian American ☐ Caucasian/White ☐ Hispanic/Latino ☐ Native American ☐ Other: _____ ☐ I do not wish to answer		
Relationship Status of Patient ☐ Single, Never Married ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed		
Employment Status ☐ Working Full Time ☐ Working Part Time ☐ Retired ☐ Unemployed		**Disability Status** ☐ N/A ☐ Short-Term ☐ Long-Term
Is the person completing this form the patient or someone else? ☐ Patient ☐ Family Member ☐ Friend		**# of people living in your home with you:**
In case of emergency, please contact: Name:	**Relationship to Patient:**	**Phone # of Emergency Contact:**

Presenting Problem(s)

Briefly describe the problem(s) you are having that brings you here:

Educational History

Highest level of education: (check one)

☐ less than high school

☐ General Education Diploma (GED)

☐ High School Diploma

☐ 2-year Associate degree

☐ some college but did not complete degree (number of years completed: _____)

☐ 4-year college degree (completed): (What was your degree/major?: _____)

☐ master's degree: (What was your degree/major?: _____)

☐ doctorate degree (PhD, MD, JD, other): (What was your degree/major?: _____)

High School Name: _____ **(Year graduated**:_____)

History of learning disabilities or READIN difficulties? ☐ Y ☐ N

History of Special Education? ☐ Y ☐ N

Honors/Advanced Placement courses? ☐ Y ☐ N

College/University: _____ **(Year graduated**:_____)

Postgraduate Education: _____ **(Year graduated**:_____)

Occupational History

Current employment: _____ From: _____ To: _____

Job Title:

Job duties:

Previous employment: _____ From: _____ To: _____

Job Title: Reason for leaving:

Job duties:

Previous employment: _____ From: _____ To: _____

Job Title: Reason for leaving:

Job duties:

Have you had any problems with work performance in your current job or any past job? ☐ Y ☐ N

NFL & Football History

College: From: To:

Position:

NFL Team: (Season) From: To:

Position:

NFL Team: (Season) From: To:

Position:

NFL Team: (Season) From: To:

Position:

Other:

Family & Psychosocial History

Where were you born? _____ Where were you raised? _____

Who raised you? ☐ both biological parents ☐ mother only ☐ father only ☐ grandparents ☐ other: _____

Parents were: ☐ married ☐ divorced ☐ separated ☐ other: _____

How many brothers or sisters do you have? _____ How old are they? _____

Quality of family relationships growing up: ☐ close ☐ supportive ☐ distant ☐ hostile ☐ other: _____

Who do you live with currently? _____

How many children?_____ What ages? _____.

MEDICAL HISTORY

Do you have any known medical problems right now? ☐ Y ☐ N	
☐ If NO, check and proceed to question below.	If **YES**, list all here:

Are you in any physical pain right now? ☐ Y ☐ N	
☐ If NO, check and proceed to section below.	If yes, where is your pain located:
	If yes, how long have you had this pain?
	On a scale of 0 to 10 (0 being none and 10 being excruciating), rate your pain right now:

Please CHECK THE BOX whether you have been diagnosed with any of the following:

☐ Stroke (If so, when?) _____
☐ Heart attack (if so, when?) _____
☐ Transient ischemic attack (TIA)
☐ Hypertension (i.e., high blood pressure)
☐ High cholesterol
☐ Diabetes
☐ Hypothyroidism
☐ Vitamin B12 deficiency
☐ Sleep disturbance
☐ Sleep apnea (if so, are treated AND compliant?): Circle: Yes or No
☐ Problems during your birth, or reaching developmental milestones (please explain): _____
☐ Head trauma with loss of consciousness

Please list the name of any medical providers you have seen **within the past year** and the reason for your visit. If you have not seen one of the provider types listed, check the box marked N/A, for Not Applicable.

Check	Type	Provider Name(s)	Reason(s)
☐	Primary Care		
☐	Mental Health Counselor		
☐	Psychiatrist		
☐	Cardiologist		
☐	Pulmonologist		
☐	Neurologist		
☐	Oncologist		
☐	Surgeon		
☐	Other -		

Please list the names and dosages of any medications you are **currently** taking. If you have brought a list of these medications with you today, check the box next to "See Attached List" and proceed to the next section

☐ See Attached List

Name of Medication	Dosage	Frequency	Prescribing Physician	Currently Taking?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Legal History

Have you ever been arrested? ☐ Y ☐ N

If so, please list the charge (e.g., DUI, Assault) and approximate date)s): _____

Psychiatric & Mental Health History

Have you **ever** received treatment for mental health (including counseling/therapy or substance abuse) problems? ☐ Y ☐ N

☐ If N/A, check and proceed.	If yes, when?
	Reason you sought treatment:
	Were you ever hospitalized for mental health? ☐ Y ☐ N
	Any mental health diagnosis? ☐ Y ☐ N If so, please list:

Complete the table below with respect to any problems you have ever experienced in the past:

Problem	Never diagnosed or treated for this problem	Approximate year I was first diagnosed	Approximate year I first received treatment	Currently receiving treatment?
Attention deficit hyperactivity disorder	☐			☐ Y ☐ N
Anxiety disorder	☐			☐ Y ☐ N
Autism or Aspergers disorder	☐			☐ Y ☐ N
Bipolar disorder	☐			☐ Y ☐ N
Depression	☐			☐ Y ☐ N
Eating disorder	☐			☐ Y ☐ N
Learning disability	☐			☐ Y ☐ N
Posttraumatic stress disorder	☐			☐ Y ☐ N
Schizophrenia	☐			☐ Y ☐ N
Tourette's	☐			☐ Y ☐ N
Other:	☐			☐ Y ☐ N

Drug & Alcohol History

☐ **Substance Use Disorder (i.e., problems with drugs or alcohol). If yes, please describe what drug(s), length of use, and any treatment received**: _____
_____
_____
_____
_____

Complete the table below with respect to any substances you currently use **and/or** have used EVER in the past.

Substance	Check if never used	Average Amount (#, $, oz, etc.) you have used each week during the last month	Age Substance Became a Problem	Approximate date of last use	Currently Using?
Alcohol	☐	☐ N/A	☐ N/A		☐ Y ☐ N
Amphetamines	☐	☐ N/A	☐ N/A		☐ Y ☐ N
Methamphetamine	☐	☐ N/A	☐ N/A		☐ Y ☐ N
Cocaine/Crack	☐	☐ N/A	☐ N/A		☐ Y ☐ N
Other Stimulants	☐	☐ N/A	☐ N/A		☐ Y ☐ N
Heroin	☐	☐ N/A	☐ N/A		☐ Y ☐ N
Hallucinogens	☐	☐ N/A	☐ N/A		☐ Y ☐ N
Opiates	☐	☐ N/A	☐ N/A		☐ Y ☐ N
Marijuana	☐	☐ N/A	☐ N/A		☐ Y ☐ N
Nicotine	☐	☐ N/A	☐ N/A		☐ Y ☐ N
Other:	☐	☐ N/A	☐ N/A		☐ Y ☐ N

END OF FORM