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Intake Questionnaire: Adult Neuropsychology Testing

Neuropsychology Patient Intake Form
Please fill out the following questions to the best of your ability

Patient Information
Please fill out the following questions to the best of your ability

Name:

Date of birth:

Sex assigned at birth:

Address:

Telephone number:

Age:

Referred by:

Referral question or presenting problem:

Primary physician (please include telephone and address):

Other specialists (include name and specialty):

Medical History
Please fill out the following questions to the best of your ability

Previous hospitalizations, surgeries or accidents (describe when occurred, age, length of stay):

Serious illnesses:

Medical problems currently affecting you:

Family history of serious illnesses:

Previous loss of consciousness related to head injury or concussion. If yes, describe circumstances, when occurred, and medical treatment:

History of seizures? If yes, describe:

Other neurological disorders (stroke, hemorrhage, etc.)? If yes, describe:

Family history of neurological illness. If yes, describe:

Current medications (name and dosage):

Vision difficulties? If yes, describe:

Hearing difficulties? If yes, describe:

Psychiatric History
Please fill out the following questions to the best of your ability

History of emotional disorder/psychiatric treatment (diagnosis if known, age diagnosed, treating physician, medications prescribed):

When did you first seek psychiatric treatment?:

For what problems did you seek treatment?:

Was treatment helpful?:

Current psychiatrist (name, when treatment started, focus of treatment):

Current medications prescribed (name, dosage):

Medications taken in the past (name, dosage):

Current therapist (name, when treatment started, focus of treatment):

Inpatient hospitalizations (hospital, age, nature, and duration of treatment):

Previous suicide attempts (age, injuries):

Family history of psychiatric treatment or illness:

Previous/current use of (age began using, how long using, current usage): Nicotine:

Previous/current use of (age began using, how long using, current usage): Alcohol:

Have you ever experienced blackouts or withdrawal symptoms?:

Recreational drug use (specify drug, age began using, how long using, current usage):

Drug of choice (if any):

Formal treatment for drug or alcohol abuse (detoxification, rehabilitation, AA, or NA)? If yes, describe:

Personal History
Please fill out the following questions to the best of your ability

Place of birth:

Where raised:

Native Language:

Right handed, left handed, or ambidextrous:

Developmental milestone (e.g. walking, talking) attained early/late/within normal limits:

Education including high school (name of institution, degree obtained, year of graduation):

School problems (repeated grades, failed classes, special education, tutoring). If any, please describe:

Have you ever been diagnosed with a learning disability or Attention Deficit/Hyperactivity Disorder? If yes, when and by whom?:

Behavioral problems as a child? If yes, describe:

Current occupation (job title, company name):

How long have you worked at your current job?:

What was your last job?:

Previous work history:

Current marital status:

If married, separated, divorced, or widowed, please note when:

Please list those individuals who are living with you currently (Name, sex, age, relationship, education, occupation, health):

Please list family members who are NOT living with you currently (Name, sex, age, relationship, education, occupation, health):

Current Complaints
Please fill out the following questions to the best of your ability

Physical symptoms and changes

- [ ] Weakness
- [ ] Numbness
- [ ] Muscle tics/twitches
- [ ] Clumsiness
- [ ] Headache
- [ ] Pain
- [ ] Dizziness
- [ ] Nausea
- [ ] Visual defects
- [ ] Hearing defects
- [ ] Problem with taste
- [ ] Problem with smell
- [ ] Bladder/bowel control
- [ ] Change in appetite/weight
- [ ] Change in sleep pattern
- [ ] Seizures
- [ ] Fainting spells
- [ ] Other

Describe other:

Any recent changes in

- [ ] Appetite/Weight
- [ ] Sleep
- [ ] Energy levels
- [ ] Sexual interest/libido
- [ ] Other

Describe other:

Behavioral concerns

- [ ] Unusual fears
- [ ] Slowed response
- [ ] Destructiveness
- [ ] Irritability
- [ ] Excessive sadness
- [ ] Self-destruction
- [ ] Stubbornness
- [ ] Sleep problems
- [ ] High activity level
- [ ] Sexual difficulties
- [ ] Aggressiveness
- [ ] Restlessness
- [ ] Nightmares
- [ ] Easily frustrated
- [ ] Eating problems
- [ ] Mood swings
- [ ] Suicidal thoughts
- [ ] Isolated
- [ ] Withdrawn
- [ ] Problems with driving
- [ ] Other

Describe other:

Intellectual concerns

- [ ] Difficulty planning or organizing
- [ ] Difficulty in completing activities
- [ ] Difficulty adapting to change (rigid)
- [ ] Inability to concentrate
- [ ] Easily distracted
- [ ] Impulsive
- [ ] Difficulty learning or remembering
- [ ] Difficulty with comprehension
- [ ] Difficulty with expression
- [ ] Gets lost easily
- [ ] Difficulty with reading
- [ ] Difficulty with math
- [ ] Periods of confusion or disorientation
- [ ] Slowed thought processes
- [ ] Changes in mood or personality
- [ ] Changes in the way you get along with others
- [ ] Changes in social activities
- [ ] Other

Describe other:

Are symptoms staying the same or getting worse?:

What is your best guess as to why the symptoms are happening?:

Has daily living at home, work, or in social situations been affected by your symptoms? If yes, describe:

What, if anything, has helped your symptoms?:

Wrap up

Please use section below to include additional relevant information: