Céline M Paillot, Ph.D. Psychological Services
Office# (203) 909-2418 Fax # 480-247-4658
652 Boston Post Rd Suite 8 Guilford, CT 06437.

Protected Health Information – Confidential Document
Neuropsychology History Form
Adult Patient Information Questionnaire

General Information

Patient's Full Name: _____

Today's Date: _____Age: _____ Date of Birth: _____

Person Completing this Form: Self /Other_____

If other - Relationship to Patient:_____

Phone Number: _____Email address: _____

Home Address: _____

_____

Who referred you to our service? Please provide contact information:

_____

_____

Is this referral a result of or related to any legal or court proceedings? If so please provide name of attorney. _____

What is the primary language spoken at home? _____

What was the first language learned? _____

Is the patient right-handed, left-handed, or ambidextrous? (Please circle)

Please list the reasons for your visit:

_____

_____

_____

What are your goals for the evaluation?

_____

_____

_____

General Medical History

Name and phone number of primary care physician:_____
Name and phone number of Psychiatrist:_____
Name and phone number of Therapist:_____
Have you had any neuroimaging (e.g., EEG/MRI/FMRI/CT)? Yes No
If yes, please bring reports if available.
Do you drive currently? Yes No If yes, have there been any incidents in the past two years (e.g., confusion/lost/ticket/accident)? Please explain:

_____
_____

Describe your use of alcohol/tobacco/recreational drugs:

Alcohol:
How often do you drink alcohol? Daily, Several times per week,
Once per week, Several times per month, Once per month ?
Several times per year, Once per year or less?
Do not drink at all, Used to drink but stopped, Date stopped_____
Usual number of drinks you consume at a time_____
Types of drinks (circle): Beer Wine Liquor other

Drugs (for each drug please specify if the use is current or past):

	Current	Past	Last Used
Pot/Marijuana			_____
Cocaine			_____
Stimulants			_____
Benzodiazepines			_____
Other sedatives			_____
PCP/Angel dust			_____
Hallucinogens			_____
Heroine/Morphine			_____
Inhalants			_____
Club Drugs			_____
Steroids			_____
Other (specify)			

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Symptom Survey

Please place a mark (√) next to each symptom that applies, and note date of onset if possible:

Physical concerns Date of Onset

Headaches _____ Dizziness _____
Balance problems _____ Strength problems _____
Urinary problems _____ Motor problems _____
Bowel problems _____ Other physical concerns?
_____

Sensory concerns

Numbness _____ Tingling _____
Visual impairment _____ Wear glasses? Yes No
Hearing impairment _____ Wear hearing aid? Yes No
Problems with taste or smell? _____ Other sensory concerns?
_____

Intellectual concerns

Problem Solving

Difficulty figuring out how to do new things _____
Difficulty figuring out problems that most others can do _____
Difficulty planning ahead _____
Difficulty changing a plan or activity when necessary _____
Difficulty thinking as quickly as needed _____
Difficulty doing things in the right order (sequencing) _____

Language and Math Skills

Difficulty finding the right word _____
Slurred speech _____
Difficulty expressing thoughts _____
Difficulty understanding what others say _____
Difficulty understanding what I read _____
Difficulty writing letter or words (not due to a motor problem) _____
Difficulty with math (e.g., making change) _____
Other language or math problems? _____

Nonverbal skills

Difficulty telling right from left _____
Difficulty drawing or copying _____
Difficulty dressing _____
Difficulty doing things I used to do automatically (e.g., brushing teeth) _____
Difficulty find way around familiar places _____
Difficulty recognizing objects or people _____
Difficulty decline in my musical abilities _____
Not aware of time _____
Slowed reaction time _____
Other nonverbal problems?_____

Awareness and Concentration
Highly distractible _____
Lose my train of thought easily _____
Mind goes blank a lot _____
Difficulty doing more than one thing at a time _____
Easily confused and disoriented _____
Don't feel very alert or aware of things _____
Tasks require more effort or attention _____

Memory
Forget where I leave things (e.g., keys, purse, etc.) _____
Forget names _____
Forget what I was about to do _____
Forget where I am or where I am going _____
Forget recent events _____
Forget appointments _____
Forget events that happened long ago _____
Forget the order of events _____
Forget facts but can remember how to do things _____
Forget faces of people I know _____
More reliant on others to remind me of things _____
More reliant on notes to remember things _____
Other memory problems? _____

Mood/Personality
Sadness and depression _____
Anxiety or nervousness _____
Stress _____
Sleep problems _____
Excessive snoring _____
Become angry more easily _____
Euphoria (feeling on top of the world) _____
Much more emotional _____
Feel as if I just don't care anymore _____
Easily frustrated _____
Less inhibited (do things I would not do before) _____
Difficulty being spontaneous _____
Change in energy? Loss Gain _____
Change in appetite? Loss Gain _____
Change in weight? Loss Gain _____
Change in sexual interest _____
Lack of interest in pleasurable activities _____
Increase in irritability _____
Increase in aggression _____

Other changes in mood or personality or in how you deal with people?

_____

Overall, my symptoms have developed Slowly or Quickly ? (Please circle)
Over the past six months my symptoms have:
Improved Stayed the same Worsened (Please circle)
Is there anything you can do (or someone does) that gets the problems to stop or be less intense, less frequent, or shorter?_____

_____

_____

What seems to make the problem worse?_____

_____

_____

Please indicate if you have a history of any of the following. If yes, please briefly describe:
Yes No Head injury?_____
Yes No Hypertension/High Cholesterol?_____
Yes No Heart Disease?_____
Yes No Stroke?_____
Yes No Seizure?_____
Yes No Neurological Disorder? (such as Parkinson's disease)?_____

_____

Yes No Cancer?_____
Yes No Headaches?_____
Yes No Diabetes/Kidney Problems?_____
Yes No Surgeries?_____
Yes No Other (e.g., thyroid problem, menopause, etc)?_____
Have others commented to you about changes in your thinking, behavior, personality, or mood? If so, who, and what have they said?

_____

_____

_____

Please list your current medications, including dosage and approximate start date:

_____

_____

_____

_____

_____

_____

Please list any medical or psychiatric diseases that run in your family:

_____

_____

_____

_____

How is your mood?_____

Do you have a history of psychiatric illness?_____
_____
Have you ever been treated for a psychiatric problem? Yes No
If yes, were you treated with medications? Did you ever receive ECT? If yes, how many times?_____ Other treatments ?
Describe_____
Were you ever hospitalized for psychiatric problems? Yes No If yes, please list the dates:_____
_____

Family History

The following questions deal with your biological mother, father, brothers, and sisters:
Is your mother alive? Yes No If deceased, what was the cause of her death?
_____
Mother's highest level of education and occupation:
_____

Is your father alive? Yes No If deceased, what was the cause of his death?
_____
Father's highest level of education and occupation:
_____

Please describe any parental family history of:
Neurological diseases (e.g., Parkinson's, Alzheimer's, multiple sclerosis):
_____
_____
Psychiatric conditions (e.g., depression, anxiety, bipolar illness, schizophrenia):
_____
_____
_____
Other disorders (e.g., problems with attention, learning, speech/language, or behavior):
_____
_____
_____
How many brothers and sisters do you have and what are their ages?
_____
_____
_____
_____

Are there any unusual problems (physical, academic, psychological) associated with any of your brothers or sisters? If yes, please describe:
_____
_____
_____

Social and Occupational History

Grade/degree completed in school:_____
Were you involved in special education?_____
Are you married? Yes No If yes - for how long?_____
With whom do you currently live?_____
Do you have children? Yes No Ages?_____
Are you unemployed, employed , or retired ?
Describe any legal problems you have had:_____
Is there any other information you would like to add?_____
_____