**Neuropsychology**
**Assessment**
**Center**
BIDMC PSYCHIATRY (HMFP)
Boston · Needham · Lexington
617-667-4749
www.nacbid.org

# Neuropsychological History

Name (Last name, First name):

**MR#:** _____

**Gender**: M F Trans Other _____

**DOB**: _____ **Age**: _____

**Marital Status** (circle): Single Married Divorced Separated Widowed

**Highest grade completed in school**: _____

**Date you are filling this out**: _____

**Inpatient or Outpatient**

**What hand do you write with?** Left Right
**What hand you lead with to throw/bat/etc.** Left Right Both (if Both describe):

**Ethnic Origin**: White Black Hispanic
Asian Haitian Other _____

**Cultural Identity?**_____

**Who referred you to us?** _____ **Phone:** _____

**Date of your last physical exam (by any Dr.):** _____

**Why are you here today**? Describe the problem or **reason for neuropsychological evaluation**:

## I. SYMPTOMS: COGNITIVE

Have you had any problems with:

| | Yes | No |
|---|---|---|
| **Thinking?** | | |
| **Memory** | | |
| **For recent events?** | | |
| **For events from a long time ago?** | | |
| **Do Cues help?** | | |
| **Concentration/Paying attention?** | | |
| **Speech?** | | |
| **Say word you did not mean to say?** | | |
| **Have difficulty finding the word you want?** | | |
| **Understanding what people say?** | | |
| **Understanding what you read?** | | |
| **Other problems reading?** | | |
| **Sense of direction?** | | |
| **Get lost more than the average person?** | | |
| **Ability to walk** | | |
| **Have you fallen lately?** | | |
| **Dropping Objects/reduced strength in hand(s)** | | |

Explain/Comments:

ADL's:

**Comments:**

Here are some questions about how you have felt and conducted yourself over the past six months. Please answer each question by putting a check-mark next to the frequency that applies: either Never, Rarely, Sometimes, Often, or Very Often

| | Never | Rarely | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| 1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done? | | | | | |
| 2. How often do you have difficulty getting things in order when you have to do a task that requires organization? | | | | | |
| 3. How often do you have problems remembering appointments or obligations? | | | | | |
| 4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started? | | | | | |
| 5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time? | | | | | |
| 6. How often do you feel overly active and compelled to do things, like you were driven by a motor? | | | | | |
| (Barkley) How often do you have trouble doing things or tasks in their proper sequence? | | | | | |

[4+ ]

## II. MEDICAL HISTORY (Individual)

### A. DEVELOPMENTAL HISTORY

Your birth was (circle one) **early late on time**

*Regarding **your mother's pregnancy** with you and **your childhood**, **check any/all**:*

| | | | |
|---|---|---|---|
| | Low birth weight | | Trouble sitting still |
| | Birth complications | | Problems with attention |
| | Mother using alcohol or drugs | | Recurrent ear infections |
| | Trouble learning to walk, talk or toilet train | | Visual problems |
| | Stuttering | | Temper tantrums |
| | Bedwetting | | Hearing problems |
| | Trouble making friends | | School behavior problems |
| | Extreme shyness | | Motor clumsiness |

**Comments:**

## B. ADULT MEDICAL HISTORY (Patient)

1. Have you been diagnosed with or treated for any of the following (check if yes)? Include Comments:

| | Disease/problem: |
|---|---|
| | **Hypertension (high blood pressure)** |
| | **Diabetes** |
| | **Heart Problems** |
| | **Neurovasc./Stroke** |
| | **Sleep disorder** |
| | **Thyroid Disease** |
| | **Kidney Disease** |
| | **Lung Disease** |
| | **Liver Disease** |
| | **TB (tuberculosis)** |
| | **Epilepsy or seizures** |
| | **Cancer** |
| | **Trauma/ Accidents** |
| | **HIV/AIDS** |
| | **Other chronic medical problems** |
| | **Any surgeries** |
| | **Ever hospitalized for a medical problem?** |

## C. HEAD INJURY

1. Did you ever lose consciousness for more than five minutes for any reason? **YES NO**
2. Did this involve a hit on the head?

   If yes,
   a. When did the injury occur? (month and year)
   b. How long were you out (unconscious) for?
   c. Were you taken to the hospital because of coma, dizziness, disorientation, nausea? **YES NO**
   d. How long were you hospitalized?
   e. Describe any changes in personality, behavior, mood, or cognitive function that followed the injury:

   f. Any additional head injuries? **YES NO**
   If yes, describe on the back or other page

## D. NEUROLOGICAL ILLNESS

1. Have you ever been treated by a neurologist for any condition such as a stroke? **YES NO**

If yes, then:
   a. Diagnosis:

   b. Date of onset:

2. Exposure to Neurotoxins

a. Have you ever worked in an environment with heated up metal, solvents, glues, or any known toxic substance? **YES NO DK**

If yes, explain:

b. Any significant symptoms related to exposure?

Check all that apply:

| During work | Several hours after work | |
|---|---|---|
| | | Numbness (where): |
| | | Tingling (where): |
| | | Feeling light-headed |
| | | Feeling "high" |
| | | Other: |

## E. TESTS/ IMAGING OF HEAD

| | | |
|---|---|---|
| Type of scan | | **CT MRI N/A** |
| Date of most recent scan | | |
| Findings: | | |
| Type of lesion | | **Vascular Infectious Contusion/trauma N/A** |
| Had EEG? | | Findings: |

Comments:

**F. HIV/AIDS Info:**

| | |
|---|---|
| **Y N** | Have you been diagnosed with HIV? |

| | |
|---|---|
| **When diagnosed HIV+** | |
| **Age diagnosed with HIV** | |
| **Most current CD4** | |
| **Viral Load** | |

## III. PSYCHIATRIC HISTORY

**Check any/all that apply:**

| | | |
|---|---|---|
| | Ever been seen by a psychiatrist, psychologist, or other mental health professional? | If yes, was it helpful? |
| | Are you currently in counseling or psychotherapy | Name of Therapist: |
| | Ever received medication for an emotional problem? | What Meds: |
| | Ever hospitalized for a psychiatric illness or mental health problem? | |
| | Current Diagnosis: | |

| | Any History of: | | |
|---|---|---|---|
| | Depression | | Schizophrenia |
| | Anxiety | | ECT treatment |
| | Panic | | Trauma exposure |
| | Bipolar Illness | | |

**Treatment** History (for example in Dr.'s office, clinic or Hospital: location dates):

4. **Current medications:**

| Name (or purpose of drug) | Dosage |
|---|---|
| | |
| | |
| | |
| | |

## A. ALCOHOL AND DRUG USE

1. How much alcohol do you use (How often and how much)?

| | Yes | No |
|---|---|---|
| **Have you ever felt you ought to cut down on your drinking?** | | |
| **Have people annoyed you by criticizing your drinking?** | | |
| **Have you ever felt bad or guilty about your drinking?** | | |
| **Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eyeopener)?** | | |

a. Age you started drinking?

b. When were you drinking the most?

c. How often and how much during peak:

d. How many years did this period last?

e. When was the last time you had a drink?

f. Have you experienced:

(1) Blackouts **YES NO**

(2) Withdrawal Symptoms such as:

(a) Shakes **YES NO**

(b) Seizures **YES NO**

(c) Hallucinations **YES NO**

| | Yes | No |
|---|---|---|
| **Ever had more than 21 drinks/week for a period of 5 years or more?** | | |

| Staff use: | |
|---|---|
| At testing: how many days abstinent? | |

Additional substances which you have used (**check any/all**):

| | Cocaine | Heroin | Marijuana | Ecstasy | LSD/ hallucinogens | ampheta-mines | Other | None |
|---|---|---|---|---|---|---|---|---|
| Ever Used | | | | | | | | |
| Used Regularly | | | | | | | | |
| Which is drug of choice? | | | | | | | | |

Comments and Pattern of substance use:

| | |
|---|---|
| Number of years drug use (approx) | |
| When was your last use? | |
| Number of months abstinent | |

| | |
|---|---|
| Staff use: | |
| At testing: how many days abstinent? | |

## IV. FAMILY MEDICAL HISTORY

### A. FAMILY NEUROLOGIC

Has anyone in the family (including grandparents) ever had:

| | Check here | Who had this? |
|---|---|---|
| Alzheimer's Disease | | |
| Huntington's | | |
| Parkinson's | | |
| Epilepsy | | |
| Left-Handedness | | |
| Heart Disease | | |
| Multiple Sclerosis | | |
| Seizures | | |
| Stroke | | |
| Other: | | |

### B. FAMILY PSYCHIATRIC/Developmental.

Who in your family has ever had or been:

| | |
|---|---|
| Major mood disorder or depression | |
| Bipolar illness, manic depressive | |
| Suicidal, or in a state of despair/crying | |
| Hospitalized for seeing visions, hearing voices, or thinking others were out to get them | |
| Schizophrenia-spectrum disorder | |
| Alcohol Abuse | |
| Drug Abuse | |
| Anxiety Disorder | |
| Learning Disability | |
| Developmental Disorder [which one(s)?] | |
| Other | |

Comments

## V. PATIENT SOCIAL HISTORY

### A. BIRTH AND REARING

Birth: Town: _____ State: _____ Country: _____

Rearing: Same as above OR:
Town: _____ State: _____ Country: _____

### B. FAMILY STRUCTURE

**1. Father:** Age, or age and date of death _____

Cause of death _____

Schooling _____

Occupation _____

**2. Mother:** Age or age and date of death _____

Cause of death _____

Schooling _____

Occupation _____

**3. Who were you raised by?** _____

**4. Siblings** (first name, age, sex, marital status, education, occupation, health)

5. **Family home atmosphere: Historical** or **Current**

Any exposure to violence, threat of violence? Y N
Approached sexually by adult or older child? Y N
Any sexual assault? Y N
Any failure to get basic needs met (neglect)? Y N

6. **Who do you consider your supports?**

7. **Marriage/ Sexual History**
   a. Marriage history (dates/ages at marriage, and outcomes of marriage(s))

   b. Any significant partners in the past 6 months? (or the 6 months preceding institutionalization)

| | |
|---|---|
| Sexual orientation | (1) Heterosexual (2) Homosexual (3) Bisexual |
| Gender Identity | Male Female Other: |

8. **Children** (age, sex, education, health, who are biological parents)

C. EDUCATION
Highest level of education (check one)

| | | Name of School | Age Graduated |
|---|---|---|---|
| | MD/Doctorate | | |
| | Masters | | |
| | Bachelors | | |
| | Associates | | |
| | High School Diploma (age: ) | | |
| | G.E.D. (grade completed: ) | | |
| | <High School (grade completed: ) | | |

| | | If so, in what grade: |
|---|---|---|
| | Ever repeated a grade | |
| | Ever special tutoring | |

| | | |
|---|---|---|
| | Ever special classes | |
| | Ever special school | |
| | Ever repeat a subject | |
| | Did you ever get into trouble in school? | |
| | Ever Suspended? | |
| | Ever expelled | |
| | Any arrests? Convictions? | |
| | Ever skip a grade | |
| | Ever been told you were hyperactive? | |
| | Ever been treated with meds for hyperactivity? | |

What language did you learn first in your life?

What other languages do you speak?

Best subject in school? Worst subject?

Scores on standardized tests **(eg. GREs, SATs):**

**D. MILITARY SERVICE**

1. Any military service **Y N** If yes, then:
    a. What branch of service?

    b. Dates of Service

    c. Any exposure to combat **Y N**

    d. What type of discharge?

E. **OCCUPATION**

1. Current Employment status (Check those that apply)

| | |
|---|---|
| employed full time | |
| employed part time | |
| Unemployed | |
| on public assistance | |
| Homemaker | |
| full-time student | |
| Part-time student | |
| Retired | |
| on disability | |

2. Looking for work? **Y N**
3. Current source of income: _____

4. Employment History
    a. List jobs (type of job/company/dates: start with current and go back in time)

    b. Date of most recent employment: _____

    c. Types of work: _____

    d. Longest ever held a job: _____

    e. Approximate # of jobs held: _____

**F. LEGAL HISTORY**

1. Any current legal issues?

2. Reported number of arrests:

3. Types of arrests:

**2.** Amount of total time spent incarcerated (in years):

| | |
|---|---|
| Have you ever been at Bridgewater State Hospital? | 1 = Y<br>2 = N |

G. CURRENT LIVING SITUATION

| **Financial:** | | **Structure:** | | **Lives with:** | |
|---|---|---|---|---|---|
| Rents | | Home | | Lives alone | |
| Owns | | Apartment | | With spouse/ partner | |
| Contributes | | Shelter | | With other family | |
| Other | | Homeless | | With non-family | |
| | | Supervised Living | | Other | |
| | | Institutionalization | | | |
| | | Other | | | |

**SLEEP BEHAVIOR**

1. How have you been sleeping?

2. What time do you usually lay down to go to bed?

3. When do you usually fall asleep?

4. Do you awaken, typically, during the night? If so, how often and for how long?

5. When do you wake up in the morning? Get up out of bed?

6. How many hours do you think you are sleeping at night?

7. Any naps during the day? If so, for how much time?

8. Do you feel well rested when you get up in the morning?