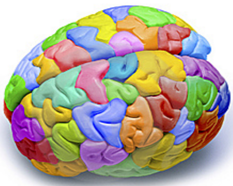

Shannon E. Taylor PhD PA

North Texas Neuropsychology and Behavioral Medicine Services

Patient Information Form – Neuropsychological

Date: ___________________

Name:____

Age:______________________Date of Birth:_______________________________

Referring doctor/facility:

____

____

Family doctor:____

Reason your doctor referred you here:

____

____

____

____

____

____

____

Handedness: □ Right □ Left

MEDICAL HISTORY

Please list any serious illnesses you currently have or have had in the past:

	Illness	Currently	If no, when in past
1.		YES NO	
2.		YES NO	
3.		YES NO	
4.		YES NO	
5.		YES NO	
6.		YES NO	
7.		YES NO	
8.		YES NO	

Please list your current medications:

Current Medications	Dosage	Times per day	Date started

Please list any previous hospitalizations/operations:

	Condition	**Date**	**Hospital**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Have you ever had:

an MRI scan?	YES NO	**If yes, when?**
a CAT scan?	YES NO	**If yes, when?**
an EEG test?	YES NO	**If yes, when?**
a Carotid Doppler test?	YES NO	**If yes, when?**
a Neuropsychological Evaluation?	YES NO	**If yes, when?**

Have you ever had any mental health concerns? YES NO
If yes, did you receive treatment (from whom, when, for what problem):

Have you ever been prescribed antidepressant or anti-anxiety medication? YES NO
If yes, describe (what medicine, who prescribed, and when):

Please list any serious illness or neurological diseases that any of your **family** has suffered:

Disease		Family member
Strokes	YES NO	
Seizures	YES NO	
Alzheimer's Disease	YES NO	
High Blood Pressure	YES NO	
Heart Disease	YES NO	
Other serious diseases		

HAVE YOU EVER HAD:

Vision Problems?	YES NO	**Glasses:**	NO YES	
		Glaucoma:	NO YES	Right eye Left eye
		Blurring:	NO YES	Right eye Left eye
		Double vision:	NO YES	
		Other:		
		Hearing aids:	NO YES	Right ear Left ear
		Ringing:	NO YES	Right ear Left ear
Hearing Problems?	YES NO	**Buzzing:**	NO YES	Right ear Left ear
		Other:		
Heard or seen things that others have not?	YES NO	Describe:		
Head injuries when you were knocked out (lost consciousness)?	YES NO	Describe incidents and length of loss of consciousness:		
Episodes when you passed out, blacked out, or fainted (lost consciousness)?	YES NO	Describe incidents and length of loss of consciousness:		

High Blood Pressure?	YES NO	Describe:
Seizures?	NO YES	**What type:** Grand Mal Petite Mal Psychomotor **How often:** **Times per:** day week month year Describe:
Headaches?	NO YES	**What type:** Tension Migraine **How often:** **Times per:** day week month year Describe:
Balance problems?	NO YES	Describe:
Urinary Incontinence?	NO YES	Describe:
Weakness in any part of your body?	NO YES	Describe:
Numbness in any part of your body?	NO YES	Describe:
Any motor vehicle accidents?	NO YES	**How many accidents?** **Were you seriously injured?** NO YES **Were you hit on the head?** NO YES **Were you knocked out?** NO YES **For how long?** minutes hours days

HAVE YOU RECENTLY HAD:

Had changes in weight or appetite?	NO YES	**Appetite change:** MILD MODERATE SEVERE **Weight change: LBS.** Loss or Gain
Felt depressed in the last two weeks?	NO YES	MILD MODERATE SEVERE
Describe your sleep pattern:		
Do you smoke cigarettes currently? Have you smoked cigarettes in the past?	NO YES NO YES	**Packs per day** **Packs per day, for years** **Year stopped:** **Other:**
Do you drink alcohol currently? Have you used alcohol in the past?	NO YES NO YES	**Drinks per week** (1 drink = 1 beer, or 1 glass of wine, or 1 mixed drink) **Drinks per day, for years** **Year stopped:** **Other:**
Do you use recreational drugs currently? Have you used recreational drugs in the past? Have you ever overused prescription medication to relieve pain or distress?	NO YES NO YES NO YES	**Please describe:** **Please describe:** **Year stopped:**
Describe your sleep pattern:		

SOCIAL INFORMATION

Marital Status:	Single	
	Divorced Widowed	How long have you lived alone?
	Married Co-habitating	How long have you lived together?
		How is the health of your partner? GOOD FAIR POOR
	# of marriages	Please list partner's health problems

Current Address	Names of People living with you	Relationship to you

Names of children not living with you	Relationship	Age	City/Town of residence

SCHOOL INFORMATION

Last school grade completed? ________Degrees Received _______________________

How would you describe your grades?

Excellent Above Average Average Poor Failing

Did you have any learning problems in school? YES NO

If yes, circle which were problem areas:

Reading Writing Math Behavioral Paying Attention

Other:____

____

If yes, did you receive any special education services? YES NO

If you left school before graduation, explain why?

____

____

List any special training or education:

____

____

WORK HISTORY

Usual Occupation:

Are you retired?	YES NO	If yes, since when:
		Type of retirement: Voluntary Medical
Are you disabled?	YES NO	If yes, since when:
		What caused the disability?
		Do you receive Social Security benefits? YES NO
		Do you receive Private Disability benefits? YES NO

Do you have a work related lawsuit? YES NO
If yes, your lawyer?____
Type: Civil Workers Comp

Please list your last several jobs.

Position	Employer	Approximate dates of employment

PSYCHOLOGICAL HISTORY

Where were you born?____

Mother's name:______________________________ **Occupation**______________

Father's name:______________________________**Occupation**_________________

Number of brothers_________________ **Number of sisters**___________________

Were your parents living together throughout your childhood?	YES NO	**If no, circle one** Divorced Death of parent: Mother Father Never married **Describe:**
How would you describe you childhood?	**Circle all that apply:** Happy Normal Difficult Troubled Lonely Idyllic Calm Sad Fearful Deprived Other (please describe):	
Did you experience any traumas, tragedies, or abuse?	YES NO	**If yes, circle all that apply:** Death of Parent Other deaths Physical abuse Sexual abuse Family violence Neglect

		Other (please describe):
Were you involved with a chronically or seriously ill person while growing up?	YES NO	**Describe:**

List any other significant events in your childhood or later life: