Scott Larson, Ph.D.
Licensed Clinical Psychologist PSY 19684

1151 Dove Street, Suite 240 Newport Beach, CA 92660

Clinical Neuropsychology Consulting | **Phone: (949) 689-6047** WWW.NewportPsychology.com | Psychological Assessment Psychotherapy

ADULT NEUROPSYCHOLOGICAL HISTORY

Patient's Name: _____

Address (Street, City, State, Zip): _____

Telephone Number: (Home) _____ **(Work)** _____ **(Other)** _____

Age: _____ **Date of Birth:** _____ **Sex:** _____ **Education:** _____

Primary Language: _____ **Secondary Language:** _____

Hand used for writing: (check one) **Right Hand:** ☐ **Left Hand:** ☐

Foot used for kicking: (check one) **Right Foot:** ☐ **Left Foot:** ☐

Current Job Title/years in position: _____

Medical Diagnosis (if any):
(1.) _____
(2.) _____

Who referred you for this neuropsychological evaluation? _____

Briefly Describe the Problem: _____

_____

_____

When did the problem begin? _____

What specific questions would you like answered by this neuropsychological evaluation?:

(1.) _____

(2.) _____

(3.) _____

(4.) _____

SYMPTOM SURVEY

For each symptom that applies, place a check mark on the line. Add any helpful comments next to the line.

1.) PROBLEM SOLVING **Date of Onset**

	Difficulty figuring out how to do new things	
	Difficulty planning ahead	
	Difficulty figuring out problems that most other people can do	
	Difficulty thinking as quickly as needed	
	Difficulty doing things in the right order (sequence problems)	
	Difficulty verbally describing the steps involved in doing something	
	Difficulty changing a plan or activity in a reasonable amount of time	
	Difficulty completing an activity in a reasonable amount of time	
	Difficulty doing more than one this at a time	
	Difficulty switching from one activity to another activity	
	Easily frustrated	
	Other problem solving difficulties:	

2.) SPEECH, LANGUAGE, AND MATH SKILLS

	Difficulty finding the right word to say	
	Difficulty understanding what others are saying	
	Unable to speak	
	Difficulty staying with one idea	
	Difficulty writing letters or words (not due to motor problems)	
	Slurred Speech	
	Odd or unusual speech sound	
	Difficulty with math (e.g., checkbook balancing, making change, etc.)	
	Difficulty understanding what I read	
	Difficulty speaking	
	Other speech, language, or math problems:	

3.) NONVERBAL SKILLS

	Difficulty telling right from left	
	Difficulty doing things I should automatically be able to do (e.g., brushing teeth, etc.)	
	Problem drawing or copying	
	Difficulty dressing (not due to physical difficulty)	
	Problems finding my way around places I've been to before	
	Difficulty recognizing objects or people	
	Parts of my body do not seem as if they belong to me	
	Unaware of time (e.g., time of day, season, year)	
	Slow reaction to time	
	Other nonverbal problems:	

SYMPTOM SURVEY (continued)

4.) CONCENTRATION AND AWARENESS **Date of Onset**

	Highly distractible	
	Lose my train of thought easily	
	Become easily confused and disoriented	
	Blackout spells (fainting)	
	My mind goes blank	
	Aura (strange feelings)	
	Don't feel very alert or aware of things	
	Other concentration or awareness problems:	

5.) MEMORY

	Forgetting where I leave things (e.g., keys, gloves, etc.)	
	Forgetting names	
	Forgetting what I should be doing	
	Forgetting where I am or where I am going	
	Forgetting events that happened quite recently (e.g., my last meal)	
	Need someone to give me a hint so I can remember things	
	Relying more and more on notes to remember how to do things	
	Forgetting how to do things, but I can remember facts	
	Forgetting faces of people I know (when they are not present)	
	Frequently forgetting appointments	
	Other memory problems:	

6.) MOTOR AND COORDINATION **Check the side this occurs on:**

		Right side	Left side	Both Sides	Date of Onset
	Fine motor control problems (e.g., using a pencil, key, etc.)				
	Weakness on one side of my body				
	Difficulty holding onto things				
	Tremor or shakiness				
	Muscle tick or strange movements				
	My writing is very small				
	My writing is very large				
	Walking more slowly than other people				
	Feeling stiff				
	Balance problems				
	Difficulty starting to move				
	Jerky muscles				
	Muscles tire quickly				
	Often bumping into things				
	Other motor or coordination problems:				

SYMPTOM SURVEY (continued)

7.) SENSORY **Check the side this occurs on:**

		Right side	Left side	Both Sides	Date of Onset
	Loss of feeling or numbness				
	Tingling or strange skin sensations				
	Difficulty telling hot from cold				
	Problems seeing on one side				
	Blurred vision				
	Blank spots in vision				
	Brief periods of blindness				
	See "stars" or flashes of light				
	Double vision				
	Difficulty looking quickly from one object to another object				
	Need to squint or move closer to see clearly				
	Losing hearing				
	Ringing in my ears or hearing strange sounds				
	Difficulty tasting food				
	Difficulty smelling				
	Smelling strange odors				
	Other sensory problems:				

8.) PHYSICAL

	Headaches	
	Dizziness	
	Nausea or vomiting	
	Urinary incontinence	
	Loss of bowel control	
	Excessive tiredness	
	Sensitivity to bright lights	
	Sensitivity to loud noises	
	Other physical problems:	

9.) BEHAVIORAL/MOOD Check all that apply to you in the past 6 months

		Rate How Severe			
		Mild	Moderate	Severe	Date of Onset
	Sadness or depression				
	Anxiety or nervousness				
	Stress				
	Sleeping problems: **(Falling Asleep ___ Staying Asleep ___)**				
	Become more angry easily				
	Euphoria (feeling on top of the world)				
	Much more emotional (e.g., cry more easily)				
	Feel as if I just don't care anymore				

SYMPTOM SURVEY (continued)

10.) BEHAVIORAL/MOOD (Continued) Check all that apply to you in the past 6 months

	Doing things automatically (without awareness)	
	Less inhibited (to do things I would not do before)	
	Difficulty being spontaneous	
	Change in eating habits:	
	Change in interest in sex:	
	Loss of energy	
	Increase of energy	
	Experiencing nightmares on a daily/weekly basis	
	Loss of sexual desire	
	Increase in weight_____ Loss of weight_____	
	Lack of interest in pleasurable activities	
	Increase in irritability	
	Increase in aggression	
	Other recent changes in behavior or personality:	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.		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?					
7.	How often do you make careless mistakes when you have to work on a boring or difficult project?					
8.	How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					

	Please continue to answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.	Never	Rarely	Sometimes	Often	Very Often
9.	How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10.	How often do you misplace or have difficulty finding things at home or at work?					
11.	How often are you distracted by activity or noise around you?					
12.	How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13.	How often do you feel restless or fidgety?					
14.	How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15.	How often do you find yourself talking too much when you are in social situations?					
16.	When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17.	How often do you have difficulty waiting your turn in situations when turn taking is required?					
18.	How often do you interrupt others when they are busy?					
19.	How often do you make decisions impulsively?					
20.	How often do you have difficulty stopping activities or behavior when you should do so?					
21.	How often do you start projects or tasks without reading or listening to directions carefully?					
22.	How often do you have poor follow-through on promises?					
23.	How often do you have trouble doing things in their proper order?					
24.	How often do you drive with excessive speed?					

11.) Overall my symptoms have developed: _____ Slowly _____ Quickly

12.) My symptoms occur: _____ Occasionally _____ Often

13.) Over the past 6 months my symptoms have: _____Stayed the same _____ Worsened

14.) In summary there is: _____ Definitely something wrong with me.
_____ Possibly something wrong with me.
_____ Nothing wrong.

EARLY HISTORY (Complete all you can for this section)

15.) You were born: _____ On time _____ Prematurely _____ Late
16.) Your weight at birth: _____ lbs. _____ oz.
17.) Was there any problems associated with your birth (e.g., oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g., need of oxygen, special equipment used, convulsions, illness, etc.)? _____ Yes _____ No
18.) Check all that applied to your mother while she was pregnant with you:

	Accident
	Alcohol use
	Cigarette smoking
	Drug use (marijuana, speed, cocaine, LSD, etc.)
	Illness (toxemia, diabetes, high blood pressure, infection, RH incompatibility, etc.)
	Poor nutrition
	Psychological problems
	Other problems:

<u>SYMPTOM SURVEY (continued)</u>

19.) List all medications (prescribed or over the counter) your mother took while pregnant

_____

_____

20.) During her pregnancy, did your mother live near a polluted area (e.g., toxic waste dump) or other hazardous area (nuclear plant, industrial area, pesticide sprayed area, etc.)?

____ Yes _____ No If yes, describe:_____

21.) Rate your developmental progress as it has been reported to you, by checking one description of each area:

	Early	**Average**	**Late**
Walking			
Language			
Toilet training			
Overall development			

22.) As a child, did you have any of these conditions: (check all that apply)

	Attentional problems		**Head Injury**
	Clumsiness		**Hearing problems**
	Developmental delay		**Hyperactivity**
	Learning disability		**Frequent ear infection**
	Speech problems		**Vision problems**
	Muscle tightness or weakness		**Depression**
	Loss of consciousness		
	Other psychiatric difficulty:		
	Other problems:		

MEDICAL HISTORY

CHILDHOOD MEDICAL HISTORY

23.) Check all the conditions that were diagnosed when you were a child. Add any helpful details (age at diagnosis, treatment, provided, etc.):

	Allergies		**Epilepsy or seizures**		**Pnuemonia**
	Scarlet fever		**Heart Problems**		**Fevers (104^0F or higher)**
	Brain infection or disease		**Immune system disease**		**Poisoning**
	Rheumatic fever		**Kidney problems**		**Polio**
	Cerebral palsy		**Lung (respiratory problems)**		**Cancer**
	Chicken pox		**Venereal disease**		**Asthma**
	Colds (excessive)		**Whooping Cough**		**Diabetes**
	Oxygen deprivation		**Tuberculosis**		**Measles**
	Meningitis		**Encephalitis**		
	Other disease or disabilities:				

SYMPTOM SURVEY (continued)

24.) As a child, were you exposed to excessive amounts of lead (e.g., eating pint chips, living next to high concentrations of automobile exhaust fumes, etc.)? _____ Yes _____ No
If yes, explain:_____

25.) As a child, did you have an accident which required a hospital visit: _____ Yes _____ No
If yes, describe what happened:_____
_____

26.) Did you ever suffer a serious injury to your head? _____ Yes _____ No
If yes, explain the circumstances and any problems you had afterwards:
_____
_____
_____

27.) How would you describe your nutrition as a child and adolescent?
_____ Excellent _____ Average _____ Poor

28.) List the medications that were regularly given to you as a child:

Medication	Reason for Medication
1.	
2.	
3.	
4.	
5.	

ADULT MEDICAL HISTORY

29.) Check all that apply:

	AIDS, ARC, or HIV+		Heart Disease
	Allergies		Huntington's Disease
	Arteriosclerosis (artery disease)		Hypertension
	Arthritis		Kidney Disease
	Blood Disease		Liver Disease
	Brain Disease		Loss of consciousness
	Cancer or chemotherapy		Lung (respiratory) Disease
	Parkinson's Disease		Malnutrition
	Psychiatric problems		Meningitis
	Senility (dementia)		Multiple Sclerosis
	Venereal Disease		Polio
	Hazardous substance exposure		Radiation exposure or therapy
	Thyroid Disease		Severe Snoring/Sleep Apnea
	Any other problems:		

MEDICAL HISTORY (continued)

30.) List any medications you currently take (over the counter or prescription medication), and the dosage.

Medication	Dosage
1.	
2.	
3.	
4.	
5.	

31.) Do you have epilepsy or seizure disorder? _____ Yes _____ No
If yes, check the one you have been diagnosed with:

PARTIAL **GENERALIZED** **_____ UNCLASIFIED TYPE**

	Simple partial (Jacksonian)		Absence (Petit small)
	Complex partial (psychomotor)		Myoclonic
	Partial evolving into generalized		Clonic
			Tonic
			Atonic
			Tonic-clonic (Grand mall)

	I have a Seizure Disorder but I don't know which type. Please describe it:

32.) Are you currently in psychotherapy or under psychiatric care? _____ Yes _____ No

33.) Have you ever been in psychotherapy or under psychiatric care? _____ Yes _____ No
If yes, please list date(s) of therapy and name(s) of professional(s) who treated you.

_____
_____
_____
_____

34.) Have you ever been prescribed medications for a mental or nervous condition (e.g., anti-anxiety medication, anti-depressants, major tranquilizer? _____ Yes _____ No

35.) Please list all inpatient hospitalizations including the name of the hospital, date of hospitalization, duration of hospitalization, and diagnosis.

_____
_____
_____
_____
_____
_____

SUBSTANCE USE HISTORY

ALCOHOL

36.) I started drinking regularly at age:
Less that 10 years old _____, 10-15 _____, 16-18 _____, 19-21 _____, over 21 _____

37.) I drink alcohol:

	Rarely or never		**1-2 days/week**
	3-5 days/week		**daily**

38.) Preferred type(s) of drinks: _____

39.) Usual numbers of drinks I have at one time: _____

40.) My last drink was:

	Less than 24 hours ago		**24-48 hours ago**		**Over 48 hours ago**

41.) Check all that apply:

	I can drink more than most people my age and size before I get drunk.
	I sometimes get into trouble (fights, legal difficulty, problems at work, conflicts with family, accident, etc.) after drinking.
	I sometimes blackout after drinking.

42.) Please check all the drugs you are now using or have used in the past:

		Presently Using	Used in the Past
	Amphetamines (including diet pills)		
	Barbiturates (downers, etc.)		
	Cocaine or crack		
	Hallucinogenics (LSC, acid, STP, etc.)		
	Inhalants (glue, nitrous oxide, etc.)		
	Marijuana		
	Opiate Narcotics (heroin, morphine, etc.)		
	PCP (or "angel dust")		
	Please list all other drugs:		

43.) Do you consider yourself dependent on any of the above drugs? _____ Yes _____ No
If yes, which one(s):_____

44.) Do you consider yourself dependent on any prescription drugs? _____ Yes _____ No
If yes, which one(s):_____

45.) Check all that apply:

	I have gone through drug withdrawal
	I have used I.V. drugs
	I have been in drug treatment

46.) Do you smoke? _____ Yes _____ No
If yes, amount per day: _____

47.) Do you drink coffee? _____ Yes _____ No
If yes, amount per day: _____

FAMILY HISTORY

The following questions deal with your biological mother, father, brothers and sisters:

MOTHER

48.) Is she alive? _____ Yes ____ No If deceased, what was the cause of her death?
_____

49.) Mother's occupation: _____

50.) Mother's highest level of education: _____

51.) Does your mother have a known or suspected learning disability? _____ Yes ____ No

FATHER

52.) Is he alive? _____ Yes ____ No If deceased, what was the cause of his death?
_____

53.) Father's occupation: _____

54.) Father's highest level of education: _____

55.) Does your father have a known or suspected learning disability? _____ Yes ____ No

56.) How many brothers and sisters do you have? _____
What are their ages? _____

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

58.) How many children do you have?

	Boys	**Age(s)**	
	Girls	**Age(s)**	

59.) Any problems (physical, academic, psychological) associated with any of your children?
_____ Yes _____ No
If yes, describe: _____
_____
_____

FAMILY HISTORY (continued)

60.) Please check all that existed in close biological family members (parents, brothers, sisters, grandparents, aunts, uncles), note who it was and describe the problem where indicated.

		Who?
	Epilepsy or seizures	
	Mental Retardation	
	Attention Deficit/Hyperactivity Disorder (ADD/ADHD)	
	Learning Disability or "dyslexia"	
	High Blood Pressure	
	Heart Disease	
	Stroke	

Neurologic (brain) Disease:

	Alzheimer's Disease	
	Huntington's Disease	
	Multiple Sclerosis	
	Parkinson's Disease	
	Other Neurologic Disease	
	Describe:	

Psychiatric Illness:

	Alcoholism	
	Bipolar Illness (manic depression)	
	Depression	
	Schizophrenia	
	Other Psychiatric Illness	
	Describe:	
	Speech or Language Disorder	
	Describe:	
	Other Major Disease or Disorder	
	Describe:	

PERSONAL HISTORY

MARITAL STATUS

61.) Current marital status: Married ___, Single ___, Divorced ___, Widowed ___, Separated ____

62.) Years married to current spouse: _____

63.) Number of times married? _____

64.) Spouse's name: _____ Age: _____

65.) Spouse's occupation: _____

66.) Spouse's health: _____ Excellent _____ Good _____ Poor

67.) Not married, but living with someone: _____ Yes _____ No
His/Her Age: _____ His/Her Name: _____

EDUCATIONAL HISTORY

68.) Highest grade or degree you've earned: _____

69.) How would you describe your usual performances as a student:

	A & B
	B & C
	C & D
	D & F

Please provide any additional helpful comments about your academic performance:

70.) What was your best subject(s)? _____
What was your weakest subject (s)? _____

71.) Were you ever held back to repeat a grade? _____ Yes _____ No
If yes, what grade (s)? _____ Reason? _____

72.) Were you ever in any special class(es) or received special services? _____ Yes _____ No
If yes, what grade? _____Or age? _____
What type of class? _____

OCCUPATIONAL HISTORY

73.) Current job title: _____

74.) Salary:

	Under $10,000.00		**$10,000.00 - $29,900.00**
	$30,000.00 - $50,000.00		**Over $50,000.00**

75.) How long have you been on this job? _____

76.) Current job responsibilities: _____

OCCUPATIONAL HISTORY (continued)

77.) Prior jobs: Start with most recent:

a.
b.
v.
d.

78.) At any time on a job, were you exposed to toxic, hazardous, noxious, or otherwise dangerous or unusual substances (e.g., lead, mercury, radiation, solvents, pesticides, chemicals, etc.)?
_____ Yes _____ No
If yes, explain: _____
_____
_____

MILITARY HISTORY

79.) Branch: _____

80.) Discharge rank: _____ **Type of Discharge:** _____

81.) Major military duties: _____

82.) Did you sustain any physical injuries in the military? _____ Yes _____ No
If yes, describe: _____
_____
_____

83.) Were you ever exposed to any dangerous or unusual substances during your service (e.g., Agent Orange, radiation, etc.)? _____ Yes _____ No
If yes, describe: _____
_____
_____

RECREATION

84.) Briefly list the types of recreation (sports, games, TV, hobbies, etc.) that you enjoy:

_____
_____
_____
_____

MEDICAL TESTING

85.) Check all the medical tests that recently have been done and report any abnormal findings:

		Check here if Normal	Abnormal Findings
	Angiography		
	Blood work		
	Brain Spect		
	CT Scan		
	EEG		
	Lumbar puncture or spinal tap		
	(MRI) Magnetic Resonance Imaging		
	Neurological Office Exam		
	Physician's Office Exam		

85.) Check all the medical tests that recently have been done and report any abnormal findings: (continue)

		Check here if Normal	Abnormal Findings
	Skull x-ray		
	Ultrasound		
	Other testing:		

86.) Identify the physician who is most familiar with your recent problems:

Name of Physician: _____

Address: _____

_____

_____

Phone:_____ **Fax:** _____**Other:**_____

Date of last medical check up: _____

Findings of last check up: _____

_____

_____

_____

_____

Date of last vision exam: _____

Date of last hearing exam: _____

87.) Have you had a prior psychological on neuropsychological evaluation? _____ Yes _____ No

If yes, complete this information:

Name of Psychologist:_____

Address: _____

_____

_____

Phone:_____ **Fax:** _____**Other:**_____

Date of and reason for evaluation: _____

Findings of the evaluation:_____

_____

_____

_____

_____