PSYCHIATRIC ASSOCIATES

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ADULT NEUROPSYCHOLOGICAL HISTORY

Patient's Name: _____ Date: _____

Address (Street, City, and Zip): _____

Patient's Telephone Number: (H): _____ (W): _____

Guardian's Telephone Number: (H): _____ (W): _____

Age: _____ Date of Birth: _____ Sex: ____ Years of Education: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Ethnic/Racial Background: _____ Religion: _____

Vision Problems (double, blurred, loss, glasses): _____

Hearing Problems (tinnitus, hearing aid) _____

Name of Referring Physician, Friend: _____

Briefly describe the reason for your visit today.

_____

_____

_____

What specific questions would you like answered by this evaluation?

1._____

2._____

3._____

List all medications that you currently take, including the dosage and any side effects.

Please include both prescription and over-the-counter medications:

Medication Name	Dosage	Side-Effects	Do you take the Medication as prescribed?

List all Current and Past Medical Problems

Circle all that currently apply

AIDS, ARC, HIV+	Heart disease	Parkinson's disease
Allergies	Huntington's disease	Polio
Arteriosclerosis	Hypertension	Psychiatric problems
Arthritis	Kidney disease	Radiation exposure
Blood disorder	Liver disease	Senility (dementia)
Brain disease/infection	Lung/respiratory disease	Stroke/ TIAs
Cancer or chemotherapy	Malnutrition	Thyroid disease
Diabetes	Meningitis	Venereal disease
Hazardous/Toxic exposure	Multiple sclerosis	Incontinence

List any additional medical issues:
_____
_____
_____

MEDICAL TESTING

Circle any medical test you have recently undergone and state any abnormal results:

TEST	NORMAL/ ABNORMAL FINDINGS
Angiography	
Blood work	
Brain scan	
CT scan	
EEG	
Lumbar puncture/spinal tap	
MRI	
Neurological office exam	
PET scan	
Physician's office exam	
Skull x-ray	
Ultrasound	
Other testing results:	

Do you have epilepsy or a seizure disorder? circle YES / NO

If "YES" circle the type diagnosed:

PARTIAL	GENERALIZED	UNCLASSIFIED TYPE
Simple, partial (Jacksonian)	Absence (Petit Mal)	
Complex Partial (psychomotor)	Myoclonic	
Partial evolving into generalized	Clonic	
	Tonic-clonic (grand mal)	
	Atonic	

If you have seizures and do not know what type, please describe them:

_____
_____

Have you ever experienced a head injury: *Circle YES / NO*

Describe the circumstances and any problems you had afterwards:

_____

_____

Were you in a coma? Circle YES or NO. How long _____?

Last clear memory prior to injury: _____?

First continuous memory after injury: _____?

Who is the physician who is most familiar with your recent problems:

Name: _____
Address; _____
Telephone: _____
Date of your last medical check-up: _____
Findings at check-up: _____

This form has been completed by: _____

If not completed by the patient, please provide the following information:

Name: _____ Relationship to Patient: _____

Address: _____

Telephone Number: (H) _____ (W) _____

Thank you for completing this information.
Please sign a <u>Release of Information</u> so we can communicate with your doctor.