INNOVATION
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Comprehensive Neurodevelopmental History

Notice to Patient: This personal history form is intended to help us gather all the information we need to help you. Everything is confidential and will not be released without your permission. Don't worry if you can't answer some of the questions, or if some do not apply to you. Just fill in the blanks as completely as you can and we will review the information with you during the initial consultation. **PLEASE PRINT OR WRITE LEGIBLY.** Thank you.

Today's Date: ______________________________________

Name: ____
(*First*) (*Middle*) (*Last*)

Gender: ☐Female ☐Male Writing hand: ☐Right ☐Left ☐Ambidextrous

Race/Ethnicity: ____

Date of Birth: ____ Age: _____________________

Highest Level of Education or Current grade: ____

Are you currently attending school? Yes ☐ No ☐

Military: Yes ☐ No ☐ If yes, please specify branch/current status: ________________________

Is English your first language? Yes ☐ No ☐ If not, what is your first language? __________________

Who referred you for this evaluation? ____

Have you ever had neuropsychological or psychological testing before? ☐Yes ☐No

If yes, by whom? ________________________________ When? ______________________________

Why? ____

If yes, please provide a copy of your report(s).

HISTORY OF PRESENTING PROBLEM

Why are you being seen for a neuropsychological evaluation (e.g. I had a stroke, I got in a car accident and sustained a head injury; Family members say I have memory problems; etc.)?

____

____

What are you hoping to learn or get out of this evaluation?

____

____

Date problem(s) began (estimate): ____

Course of illness/symptoms: ☐Getting Better ☐Getting Worse ☐Staying the Same

CURRENT PROBLEMS

Please check ALL Categories that apply. Each Category has samples to assist you in your selection.

☐ **ATTENTION PROBLEMS**	
Frequently missing details, making careless errors	Difficulty paying attention for long periods of time
Easily distracted	Difficulty following instructions

☐ **PROCESSING SPEED**	
Difficulty thinking quickly	Feeling as though most people talk too fast
Taking longer to complete tasks than before	Frequently asking people to repeat themselves (not due to hearing difficulty)

☐ **LEARNING & MEMORY**	
Difficulty remembering recent events, names, faces, the date, etc.	Difficulty learning and remembering new information
Loss of long-term memories	Forgetting to take medication

□ EXECUTIVE FUNCTIONING	
Acting before thinking	Difficulty problem solving, or making bad decision
Difficulty following multi-step direction	Difficulty planning and organizing

□ NON-VERBAL/VISUAL SPATIAL SKILLS	
Getting lost in familiar locations	Problems Driving
Inappropriate use of objects (i.e. remote as hat)	Right-Left or directional disorientation

□ SPEECH & LANGUAGE	
The feeling that a word is on the tip of your tongue	Mislabeling items (ex. Clock vs. watch)
Reduced speech volume	Difficulty understanding others or following conversations

□ MOTOR & COORDINATION	
Difficulty buttoning a shirt	Difficulty opening medicine bottles
Difficulty with walking or balance/ recent falls	Shakiness/Tremor

□ SENSORY	
Reduced sense of smell	Tingling sensation
Loss of feeling in part of your body	Difficulty perceiving your bodies location in space

□ PHYSICAL PROBLEMS	
Frequent headaches	Bowel or Bladder Incontinence
Dizziness, nausea, vomiting	Shortness of Breath
Sleep Disturbance/ Weight Change	Pain

☐ **MOOD & BEHAVIOR**	
Increased irritability	Hallucinations (visual, auditory, or olfactory)
Increased Sadness/ Crying for unknown reasons	Increase nervousness, suspiciousness, etc.
Thoughts of harming yourself or taking your life	Discomfort in Social Situations

☐ **RECENT OR CURRENT LIFE STRESSORS**	
Change in job	Change in marital status
Death of loved one	Financial or legal problem
Moved to a new location	Taking care of aging or ill loved one

**Please rate your overall stress level: ☐ Very Low ☐ Low ☐ Average ☐ High ☐ Very High

What is the greatest source of your stress at this time? ____

____

ACTIVITIES OF DAILY LIVING

If applicable:
Do you drive? Yes ☐ No ☐
Who does the cooking at home? ☐ Myself ☐ Another Person
Do you manage your own finances? Yes ☐ No ☐
Do you manage your own medications? Yes ☐ No ☐
Hygiene Problems? Yes ☐ No ☐

PATIENT MEDICAL HISTORY

Have you had any blood work or imaging (e.g., CT, MRI, X-Ray) done in the past year?
Yes ☐ No ☐

If yes, what did you have done: ____

*****If yes, please provide us a copy of your records.**

Please check the box to indicate any problems you (or patient if minor) have been identified as having and note (estimate) the year of diagnosis.

NEUROLOGIC	DATE	ENDOCRINE	DATE
□ Brain Injury		□ Diabetes	
□ Brain Aneurysm		□ Hypoglycemia	
□ Migraines		□ Hypothyroidism	
□ Movement Disorder		□ Hyperthyroidism (e.g., Graves)	
□ Brain or Spinal Tumor		□ Parathyroid Disorder	
□ Stroke		□ Adrenal Gland Disorder (e.g., Addison's)	
□ Seizures		□ Kidney Disorder	
□ Dementia		□ Cushing's Syndrome	
□ Narcolepsy		□ Low Testosterone	
□ Sleep Disorder		□ Menopause	
CARIOVASCULAR	**DATE**	**NOSE, EAR, THROAT**	**DATE**
□ High Blood Pressure		□ Dizziness (e.g., vertigo, BPPV)	
□ High Cholesterol		□ Chronic Ear Infections	
□ Heart Disease		□ Swallowing Disorder	
□ Arteriosclerosis		□ Macular Degeneration	
□ Blood Disease (e.g., anemia)		□ Cataracts or Glaucoma	
GENITAL-URINARY/ GASTRO-INTESTINAL	**DATE**	**MUSCULAR-SKELETAL**	**DATE**
□ Bowel or Bladder Incontinence		□ Amputation	
□ Colon Disease (e.g., Crohn's, IBS)		□ Arthritis	
□ Regular Urinary Tract Infections		□ Degenerative Joint Disease	
□ Gastroesophageal Reflux Disease		□ Osteoporosis	
□ Pancreatitis		□ Fibromyalgia	
□ Liver Disease (e.g., hepatitis)		□ Chronic Fatigue Syndrome	
ONCOLOGY	**DATE**	**GENETIC**	**DATE**
□ Type & Site of cancer:		□ Type (e.g., Fragile X, Down Syndrome, Mitochondrial Disease):	

MENTAL HEALTH	DATE	OTHER:	DATE
□ Anxiety Disorder			
□ Mood Disorder (e.g., Depression, Bipolar)			
□ Psychotic Disorder (e.g., Schizophrenia)			
□ Substance Use Disorder			

Have you ever experienced loss of consciousness? Yes ☐ No ☐

Explain: ____

Surgeries? Yes ☐ No ☐

If yes, please complete the following:

REASON	DATE	LENGTH OF STAY

Hospitalization(s)? Yes ☐ No ☐

If yes, please complete the following:

REASON	DATE	LENGTH OF STAY

Temperature over 104 degrees? Yes ☐ No ☐
Date(s): ____

Please list ALL medications you (or patient if minor) are currently taking.

Medication	Dose	How often do you take it?	Reason

FAMILY MEDICAL HISTORY

Please check any diagnoses that your family members (blood relatives) have.

Medical Condition	Mother	Father	Mother’s Mother	Mother’s Father	Father’s Father	Father’s Mother	Sibling	Other
Dementia								
Seizures								
Movement Disorder (e.g., Parkinson’s)								
Multiple Sclerosis								
Migraines								
Stroke								
Diabetes								
Hypertension								
Cancer								
Hyper-/hypothyroidism								
Genetic Disorder								
Learning Disability								
Dementia								

PATIENT SOCIAL HISTORY

Where were you born? ____

Where were you raised____

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed ☐ Other

Years Married (if applicable): ___________

Do you have Children: Yes ☐ No ☐ If yes, please list their ages: _________________________

Number of Marriages: _________

Currently living in: ☐ House ☐ Condo/Apartment ☐Assisted Living Facility ☐Nursing Home

Please list everyone currently living in your household:

NAME	RELATIONSHIP	AGE

PATIENT DEVELOPMENAL HISTORY

I. Pregnancy and Delivery (Your biological mother; please fill out as much as you know)

Duration of pregnancy (weeks) ___________________ (full term = 40 weeks)

Check any of the following problems that occurred during the pregnancy with you, providing you have the information:

- ☐ Excessive vomiting
- ☐ Threatened miscarriage
- ☐ Spotting/ bleeding
- ☐ Infections
- ☐ Toxic exposure
- ☐ Trauma (*physical/mental)*
- ☐ RH incompatibility
- ☐ Diabetes
- ☐ Toxemia
- ☐ High blood pressure (*hypertension*)
- ☐ Anemia
- ☐ Physical Injury
- ☐ Drinking (*How much?* ___________)
- ☐ Smoking (*How much?* __________)
- ☐ Drug abuse (*Which drugs?* ________)

Delivery

Labor: ☐ Spontaneous ☐ Induced Duration (*hours*) _______

Delivery: ☐ Vaginal ☐ Breech ☐ C-Section Apgar scores (*if known*)_________

Birth weight: Lbs _______ Oz _______

Complications: ☐ Cord around neck ☐ Hemorrhage ☐ Forceps ☐ Bruising
☐ Oxygen deprivation ☐ Birth injury ☐ Required oxygen ☐ Transfusions
☐ Other complications? ____

Did you have:

- ☐ Problems sucking
- ☐ Problems swallowing
- ☐ Feeding problems
- ☐ Problems growing
- ☐ Unusual stiffness
- ☐ Problems sleeping
- ☐ Excessive sleep
- ☐ Milk allergies
- ☐ Other allergies
- ☐ Other ____

What is known about your behavior, mood, and temperament for the first **18-25** months?
____

II. Developmental progression

Developmental milestones (*age achieved*) Please be as precise as possible.

1. _______ Rolled over? 2. _____ Sat up? 3. _____ First words?
4. _______Sentences? 5. _____ Bladder trained (day)? 6. _____ Bladder trained (night)?
7. _______ Bowel trained? 8. _____ Walked?

Were any of the following present to an **<u>unusual</u>** degree during the **first six years** of life?

- ☐ Allergies
- ☐ Ear infections
- ☐ Tubes (i.e. for ear infections)
- ☐ Eating problems
- ☐ Drooling
- ☐ High fevers
- ☐ Headaches
- ☐ Restless
- ☐ Disrupted sleep
- ☐ Not easily calmed
- ☐ Difficult to console
- ☐Into everything/Climbing
- ☐ Other ___________________________
- ☐ Poisoning/Toxic exposure
- ☐ Poor weight gain
- ☐ Lethargic
- ☐ Colic
- ☐ Head-banging
- ☐ Clumsy, uncoordinated
- ☐ Unusual number of accidents
- ☐ Aggressive
- ☐ Thumb-sucking
- ☐ Nightmares
- ☐ Easily agitated
- ☐ Unresponsive

Childhood history of (check where applicable)

______ Abuse	______ Motor Problems
______ Head Injury	______ Seizures
______ High Fevers	______ Speech Problems
______ Stuttering	_______ Other:_________________

Are you (or patient if minor): ☐ Right-handed ☐ Left-handed ☐ Ambidextrous?

When did handedness become evident? ___________________________________

Did you ever change handedness? Yes ☐ No ☐

Family history of left handedness? Yes ☐ No ☐

FAMILY HISTORY

Biological Mother: ____ Age: _______

Highest grade completed? _______________________

Occupation? ____

Have any of your **maternal** blood relatives experienced problems similar to those you are currently experiencing? *If so, please describe:* ____

____

Biological Father: ____ Age: ______

Highest grade completed? _______________________

Occupation? ____

Have any of your **paternal** blood relatives experienced problems similar to those you are currently experiencing? *If so, please describe:* ____

____

Please list all of your siblings:

First Name Only	*Age*	*Medical/Social/School problems*

Check all that apply:

Maternal:

- ☐ Learning problems
- ☐ School problems
- ☐ Attention/Concentration problems
- ☐ Hyperactivity
- ☐ Anxiety
- ☐ Obsessive Compulsive Disorder
- ☐ Unreasonable fears (phobias)
- ☐ Depression
- ☐ Suicide
- ☐ Alcoholism
- ☐ Drug abuse
- ☐ Psychiatric hospitalization
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ Other _________________________

Paternal:

- ☐ Learning problems
- ☐ School problems
- ☐ Attention/Concentration problems
- ☐ Hyperactivity
- ☐ Anxiety
- ☐ Obsessive Compulsive Disorder
- ☐ Unreasonable fears (phobias)
- ☐ Depression
- ☐ Suicide
- ☐ Alcoholism
- ☐ Drug Abuse
- ☐ Psychiatric hospitalization
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ Other ___________________________

PATIENT ACADEMIC HISTORY

Is the patient currently enrolled in school? If so, what grade? _______________

School Name: ____

If minor, does your child currently participate in special education programming? Yes ☐ No ☐

What category is the IEP under? ______________________

Trouble making friends: Yes ☐ No ☐

Please provide a copy of your IEP

If you are no longer enrolled in school, please complete the following:

Rate your school experiences (if applicable).

Preschool	☐ Good	☐ Average	☐ Poor
Kindergarten	☐ Good	☐ Average	☐ Poor
Grade School	☐ Good	☐ Average	☐ Poor
Junior High	☐ Good	☐ Average	☐ Poor
High School	☐ Good	☐ Average	☐ Poor
College	☐ Good	☐ Average	☐ Poor

Did you have any academic difficulty? Yes ☐ No ☐
Were you diagnosed with a Learning Disability? Yes ☐ No ☐
Were you (or patient if minor) ever retained for any reason or was retention ever been suggested?
Yes ☐ No ☐
If yes, please explain ____

Have you ever been in resource or special education placement? Yes ☐ No ☐
If yes, please explain ____

Have you ever been referred for special education? Yes ☐ No ☐
If yes, please explain ____

Trouble making friends: Yes ☐ No ☐

Current struggles with making and maintaining relationships: Yes ☐ No ☐

OCCUPATIONAL HISTORY

☐ **Not Applicable as Patient is a minor/No employment history**

Are you employed outside the home? Yes ☐ No ☐
If yes, what is your occupation? _________________ How many hours per week do you work? ______
If no, are you unable to work because of an injury or illness? Yes ☐ No ☐

Last date worked: ___________ If not working now, what was your former occupation? ____________
Did you serve in the Military? Yes ☐ No ☐

If yes, Branch: _________________________ Years Served: __________________

MOS: _________________________________

Discharge Rank: ________ Type of Discharge: ______________________

Deployment History: ____

Combat experience: Yes ☐ No ☐ if Yes,
Describe:____

Service connected disability: Yes ☐ No ☐ If yes, Describe_________________________________
____

SUBSTANCE ABUSE HISTORY

☐ **Not Applicable as Patient is a minor and No substance use history**

Do you smoke? Yes ☐ No ☐ *If yes, how much?* ____
Have you quit smoking? Yes ☐ No ☐ *If yes, when did you stop?* ____________________________

How much alcohol do you drink (amount/days per week/times per day)? __________________________
____
Have you ever been arrested for DUI/DWI? Yes ☐ No ☐ *If yes, when?* _______________________
Have you ever been treated for problems related to alcohol use? Yes ☐ No ☐ *If yes, when?* _______
Have you ever used street drugs (including marijuana) regularly? Yes ☐ No ☐ *If yes, which ones?*
____

Substance abuse: Yes ☐ No ☐
Type, frequency, main choice, last used: ____

Caffeine intake: Yes ☐ No ☐
Type / Amount ____

Smoking: Yes ☐ No ☐ If yes, Amount (i.e., packs per day) ____________________
If quit, when? ______ / ______ / ________

Neurotoxin exposure: Yes ☐ No ☐
If yes, Type & Date
____

LEGAL HISTORY

☐ **Not Applicable as Patient is a minor and/or no legal history**

Arrests: Yes ☐ No ☐ If yes, Number of arrests: ________

Reason/Charges:____

Convictions: Yes ☐ No ☐

Charges: ____

PATIENT PSYCHOLOGICAL HISTORY

All adults exhibit, to some degree, the behaviors listed below. Check those that you believe you exhibit to an <u>excessive</u> or <u>exaggerated</u> degree compared to others of the same age:

Behavioral:

☐ Hyperactivity
☐ Impulsivity
☐ Low frustration tolerance
☐ Interrupting frequently
☐ Sudden acts of aggression
☐ Depression
☐ Acting as if 'driven by a motor'
☐ Temper outbursts
☐ Aggression
☐ Disorganized
☐ Accident prone
☐ Nail-biting
☐ Excessive Swearing
☐ Sloppiness
☐ Anxiety
☐ Social Withdraw

Cognitive:

☐ Tics/twitching
☐ Sleep-walking
☐ Clumsiness
☐ Avoidance of Reading
☐ Not listening
☐ Poor memory
☐ Not thinking logically
☐ Problems understanding jokes
☐ Problems finding the 'right' word
☐ Poor awareness of time
☐ Poor attention span
☐ Problems expressing thoughts or ideas
☐ Difficulty finishing tasks
☐ Difficulty listening
☐ Problem expressing emotion
☐ Not learning from mistakes/experience
☐ Getting lost easily

If you checked any of the above, please specify the frequency/duration of these problems (example: Anxiety: 5 days per week, 2 times per day):

____
____
____

When did these problems begin (age/year)? ____

Did you begin to experience these symptoms after an injury or following increased substance use?
Yes ☐ No ☐
If yes, please explain: ____

Have you (**or patient if minor**) ever received any psychological or psychiatric treatment? Yes ☐ No ☐
If yes, by whom and when? ____

Please list <u>all</u> of the doctors, therapists, and other providers treating you right now.

Name	Specialty	Phone Number

Have you (or patient if minor) experienced any of the following?

Formal diagnosis of emotional psychiatric problems?	Yes ☐	No ☐
Treatment by a psychiatrist, psychologist, or psychotherapist?	Yes ☐	No ☐
Hospitalization for emotional or psychiatric problems?	Yes ☐	No ☐
Taken medication for emotional or psychiatric problems?	Yes ☐	No ☐

If you checked any of the above, please specify diagnosis and dates/reason for treatment:
____
____
____

Neurological History

Complete this section **ONLY** if you (**or patient if minor)** have seen a neurologist or neurosurgeon for some diagnosed disease or injury (e.g., brain tumor, seizures, infectious diseases of the brain, head injury).

Check all that apply to you:

☐ Birth injury
☐ Brain tumor
☐ Meningitis
☐ Head injury/concussion
☐ Spinal cord injury
☐ Endocrine problems
☐ Cerebral Palsy
☐ Traumatic brain injury
☐ Developmental disorder
☐ Seizures
☐ Encephalitis
☐ Headaches
☐ Other (*specify*) ____________________________

Age at initial diagnosis __________

Presenting complaints or symptoms:
____
____
____

Diagnosis ____

Current neurologists/neurosurgeons:
____
____

Previous neurologists/neurosurgeons that have seen you:
____
____

Have you had or are you having seizures currently? _____________________
Date of last seizure? _____________________

Diagnostic procedures completed:

☐ CT Scan *date(s)* ___________________
☐ MRI Scan *date(s)* ___________________
☐ SPECT Scan *date(s)* ___________________
☐ PET Scan *date(s)* ___________________
☐ Spinal Tap *date(s)* ___________________
☐ EEG *date(s)* ___________________

Hospitalizations: (*include date and reason*)

____
____

Have you noticed any problems in your sense of:

- ☐ vision
- ☐ hearing
- ☐ smell
- ☐ taste
- ☐ touch

Are you having any problems with:

- ☐ alertness
- ☐ anger
- ☐ appetite
- ☐ balancing checkbook
- ☐ concentration
- ☐ coordination
- ☐ dizziness
- ☐ driving
- ☐ energy
- ☐ fainting
- ☐ headaches

Are you having any problems with:

- ☐ irritability
- ☐ memory
- ☐ numbness
- ☐ pain
- ☐ reading
- ☐ sadness
- ☐ sense of direction
- ☐ sleep
- ☐ speech
- ☐ balance in walking
- ☐ weakness
- ☐ writing

If you checked any of the above, please specify the frequency/duration of these problems (example: Anger outbursts 5 days per week, 2 times per day):

____
____

Additional Remarks

Please write any additional remarks you may wish regarding your problems:

____
____
____
____

Prefrontal Problems

1 2 3
- ☐ ☐ ☐ short attention span
- ☐ ☐ ☐ distractibility
- ☐ ☐ ☐ impulsivity
- ☐ ☐ ☐ procrastination
- ☐ ☐ ☐ disorganization
- ☐ ☐ ☐ misperceptions
- ☐ ☐ ☐ judgment
- ☐ ☐ ☐ restlessness/hyperactivity
- ☐ ☐ ☐ poor motivation

Cingulate Problems

1 2 3
- ☐ ☐ ☐ worrying
- ☐ ☐ ☐ holds grudges
- ☐ ☐ ☐ stuck on thoughts
- ☐ ☐ ☐ stuck on behaviors
- ☐ ☐ ☐ argumentativeness
- ☐ ☐ ☐ oppositional behavior
- ☐ ☐ ☐ addictive behaviors
- ☐ ☐ ☐ cognitive inflexibility
- ☐ ☐ ☐ needing things done a certain way

Temporal Lobe Problems

1 2 3
- ☐ ☐ ☐ periods of aggressiveness
- ☐ ☐ ☐ illusions/hallucinations
- ☐ ☐ ☐ periods of amnesia
- ☐ ☐ ☐ déjà vu, other odd sensations
- ☐ ☐ ☐ reading/auditory processing problems
- ☐ ☐ ☐ panic/fear for little reason
- ☐ ☐ ☐ spaciness/confusion
- ☐ ☐ ☐ excessive religiosity/evil or scary thoughts
- ☐ ☐ ☐ persistent suicidal ideation

Limbic Problems

1 2 3
- ☐ ☐ ☐ moodiness, irritability, clinical depression
- ☐ ☐ ☐ increased negative thinking
- ☐ ☐ ☐ perceive events in a negative way
- ☐ ☐ ☐ decreased motivation
- ☐ ☐ ☐ flood of negative emotions
- ☐ ☐ ☐ appetite and sleep problems
- ☐ ☐ ☐ social isolation
- ☐ ☐ ☐ decreased/increased sexual responsiveness

Learning Problems

1 2 3
- ☐ ☐ ☐ reading problems
- ☐ ☐ ☐ switching/reversing letters or numbers
- ☐ ☐ ☐ problems remembering what is read
- ☐ ☐ ☐ poor handwriting
- ☐ ☐ ☐ trouble putting thoughts on paper
- ☐ ☐ ☐ math problems
- ☐ ☐ ☐ sequencing problems
- ☐ ☐ ☐ memory problems
- ☐ ☐ ☐ sensitivity to light
- ☐ ☐ ☐ misperceive others
- ☐ ☐ ☐ uses wrong words in speech

Basal Ganglia Problems

1 2 3
- ☐ ☐ ☐ anxiety, nervousness
- ☐ ☐ ☐ panic attacks
- ☐ ☐ ☐ tendency to predict the worst
- ☐ ☐ ☐ negative patterns from past control behavior
- ☐ ☐ ☐ trouble dealing with conflict

1 = mild intensity
2 = moderate intensity
3 = sever intensity
No check = no problem or not discussed