

ADULT NEUROBEHAVIORAL HISTORY FORM

Patient

Appointment

Form Completed By

Date Completed

It is very important to understand an individual's medical and personal history to formulate a complete understanding of symptoms and identify a specific diagnosis. Although this form is quite long, your taking time to respond to the questions, providing detailed accurate responses will greatly help in understanding the symptoms you are experiencing. This will also help to identify the most appropriate treatment plans and strategies. This material will be reviewed at the initial intake visit. In the context of that visit, additional observations can be discussed to determine what additional information may be necessary and/or if testing may be of benefit.

You may wish to ask parents, spouse, other family or friends for information to help your memory. For many problems, there is often a genetic family history, as many problems are inherited (e.g., depression, learning problems, anxiety disorders).

Please bring these completed forms with you to your first appointment.

The NeuroDevelopment Resource Center

Boise Office

950 West Bannock St., Suite 1100
Boise, ID 83702
(208) 947-5368
(888) 328-9210 fax

Salt Lake City Office

2150 South 1300 East, Suite 500
Salt Lake City, UT 84106
(801) 532-1475
(888) 328-9210 fax

www.neurodevcenter.com

I. GENERAL PATIENT INFORMATION

Full Legal Name _____ Birth Date _____ Sex: M F

Mailing Address _____ Home Phone () _____
Street
_____ Work Phone () _____
City State Zip

e-mail address _____ Cell Phone () _____

Referred by _____
Address _____ Phone _____

What is your understanding of the reason for referral? _____

Give a brief account of the history and developmental of the symptoms of concern presently (i.e., onset to present) _____

On the scale below, how would you rate the severity of your symptoms? (circle one)

Mildly Upsetting Moderately Severe Very Severe Extremely Severe Totally Incapacitating

Current Occupation _____ Social Security Number _____
Currently Employed By _____ Total Years Education _____

Marital Status: Single Married Divorced Remarried Widowed Spouse _____

Please list marriages, current and previous, with dates of: _____

Children, if any: (Please list biological, step and/or adopted children)

Hobbies _____

Recreational activities _____

Particular areas of interest _____

II. MEDICAL/PERSONAL HISTORY

Date of birth _____ Place of birth _____
Birth weight (if known) _____ Complications at birth? _____

As a child, did you have any of the following?

- premature birth
- low birth weight
- birth complications/injury
- vision problems
- night terrors
- bed-wetting
- birth defects
- hearing problems
- other _____

Any history of learning disorders, school problems, or related difficulty? _____

Handedness: Right? _____ Left? _____ Ambidextrous? (uses both hands) _____
Family history of left handedness? _____

Family History:

	Name	Age	Education (years)	Living?	Reason for death
Parents	_____	_____	_____	_____	_____
Siblings	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Father's education: _____ Occupation: _____
Mother's education: _____ Occupation: _____

Any major health problems diagnosed in your immediate or extended family (e.g., diabetes)? _____

Any family history of psychiatric history or behavior disorders (e.g., depression, anxiety, "nervous breakdowns," Attention Deficit Hyperactivity Disorder, alcoholism, other substance abuse)? _____

Did you have any major childhood illnesses or injuries besides general pediatric illnesses (e.g., measles, mumps, chicken pox)? Yes No Please list/describe _____

Have you had any major illnesses or injury, with or without hospitalization? Yes No Please describe _____

Have you personally had any previous neurologic injuries or illnesses (e.g., head injury, loss of consciousness, encephalitis) as a child, adolescent, or adult? Yes No Please list: _____

Have you personally ever been treated for any psychiatric or behavioral disorder (e.g., ADHD, substance abuse, depression)? Yes No If so, when: _____

What medications, if any, were prescribed: _____

Have you ever had any of the following?

_____	Head injury (TBI)	Explanations:
_____	Automobile accident(s)	
_____	Neurologic disease or injury	
_____	Heart problems	
_____	Near drowning	
_____	Alcohol/substance abuse	
_____	High blood pressure	
_____	Heart disease	
_____	Cancer	
_____	Blood disorder	
_____	Depression	
_____	Anxiety	
_____	Serious infection	
_____	Meningitis	
_____	Encephalitis	
_____	Diabetes	
_____	Liver or kidney disease	
_____	Stroke	
_____	Unusually extreme temper	
_____	Hospitalizations	
_____	Poisoning	
_____	Toxic exposures	
_____	Headaches	
_____	Paralysis	
_____	Deafness/hearing loss	
_____	Visual problems	
_____	Back/neck injury	
_____	"Nervous breakdown"	
_____	High fevers	
_____	Seizures	
_____	Other _____	
_____	Other _____	

Medications you currently take:

Medication	Dose (mg)	How taken? (e.g., two times daily, three times daily)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other medications you have previously taken for long periods of time (but no longer take) _____

Height _____ Weight _____

Do you currently smoke? Yes No How much? _____ When did you start? _____
If no, have you ever smoked? Yes No How long since stopped smoking? _____

Do you currently drink (i.e., alcohol)? Yes No Describe drinking habits _____
If no, have you ever drank? Yes No

Has your drinking ever caused problems? Yes No Explain _____

Do you (or have you) use "recreational" drugs (e.g., marijuana, cocaine, crack)? Yes No Explain _____

Have you ever been addicted to prescription drugs? Yes No Explain _____

Were you in trouble with the law as a teenager? Yes No Explain _____

Have you been in trouble with the law as an adult? Yes No Explain _____

Underline any of the following that apply to you:

Headaches
Rapid heart beat
Bowel disturbances
Nightmares
Feel tense
Depressed
Unable to relax
Don't like weekends
and vacations
Can't make friends
Can't keep a job
Financial problems

Dizziness
Stomach trouble
Fatigue
Take sedatives
Feel panicky
Suicidal
Sexual problems
Over ambitious
Inferiority problems
Memory problems
Concentration
difficulties

Fainting spells
No appetite
Insomnia
Alcoholism
Tremors
Take drugs
Shy with people
Can't make decisions
Home conditions uncomfortable
Unable to have a good time
Other: _____

III. EDUCATIONAL HISTORY

1. List schools attended (public or private), grade school through high school.

School	Grades	City, State

Graduated high school? Yes No _____ GED? Yes No _____
 Estimated high school GPA: _____ School records available? _____
 Extra curricular activities? _____

Educational support required?

- | | | |
|---|---|--|
| <input type="checkbox"/> Started school late | <input type="checkbox"/> Held back/repeated grade | <input type="checkbox"/> Behavior problems |
| <input type="checkbox"/> Resource/special education | <input type="checkbox"/> Underachiever | <input type="checkbox"/> Learning problems |
| <input type="checkbox"/> Tutoring | <input type="checkbox"/> Poor motivation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Remedial Classes | <input type="checkbox"/> Attention/concentration problems | |

Please explain any of the above _____

What factors detracted from a successful school experience? _____

Best and worst academic areas? _____

Post high school education:

Trade School (list others on back) _____
 Describe course work _____
 Years attended _____ Estimated GPA: _____ Certification/Diploma? _____
 List apprenticeships, courses, other training: _____

Community College _____
 Describe course work/major _____
 Years attended _____ Estimated GPA: _____ Certification/Diploma? _____

University/College (list additional schools on back) _____
 Major/minor _____
 Years attended _____ Estimated GPA: _____ Certification/Degree? _____

Graduate Training Completed:

University _____ Years attended _____
 Graduate area of study _____
 Degree/date _____ Estimated GPA: _____

IV: VOCATIONAL/OCCUPATIONAL HISTORY

Employment during high school _____

Employment during college _____

Current occupation _____ How long? _____
Employer _____ Job description _____

Do you enjoy your current employment? Yes No Explain _____

Previous employer _____ How Long? _____
Job Description _____

Previous employer _____ How Long? _____
Job Description _____

Previous employer _____ How Long? _____
Job Description _____

(Use back of page if necessary)

V: MILITARY EXPERIENCE

Branch _____ Highest rank _____

Specialty areas _____ Honors _____

Training (describe) _____

Testing completed _____

Military records available? _____

VI: DETAILS OF THE ACCIDENT//INJURY

Date of accident/injury _____ Details of accident/injury _____

Loss of consciousness? Yes No Estimated length of unconsciousness _____

Specific Injuries _____

Who did you see right after the accident? (e.g., emergency room, hospitalization, personal physician, etc.):

Describe symptoms right after the injury _____

Describe symptoms of concern now, including how they have changed over time (use back if necessary) _____

Health care providers previously consulted:

Name	Specialty
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Health care providers currently involved in treatment:

Name _____	Specialty _____
Describe treatment _____	
Name _____	Specialty _____
Describe treatment _____	
Name _____	Specialty _____
Describe treatment _____	
Name _____	Specialty _____
Describe treatment _____	

Injuries which have resolved: _____

Injuries for which you are currently being treated: _____

Diagnostic studies available:

_____ X-rays (specify) _____	By: _____
_____ CT scan _____ <small>date(s)</small>	By: _____
_____ MRI _____ <small>date(s)</small>	By: _____
_____ EEG _____ <small>date(s)</small>	By: _____
_____ SPECT _____ <small>date(s)</small>	By: _____
_____ Neuropsychological Evaluation(s) _____ <small>date(s)</small>	By: _____

Other diagnostic procedures _____

Do you experience headaches? Yes No Frequency _____

Mild 1 2 3 4 5 6 7 8 9 10 Severe

Have your sleeping patterns changed? Yes No If yes, please describe _____

