CHICAGOLAND COGNITIVE ASSESSMENT CENTER LLC
Maia Feigon, PhD, ABPP

NEUROPSYCHOLOGY HISTORY FORM

Please fill out this form to the best of your knowledge. If some questions are not applicable to you, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet. Completing this form thoroughly will reduce interview time.

Form completed by: _____ **Relationship to patient** _____ **Date:**

General Information

Patient's Name: _____ **Gender:** ☐ **Male** ☐ **Female** ☐ **Non-Binary**
First *Middle* *Last*

Date of Birth: _____ **Age:** _____ **Ethnic/Cultural Background (optional)** _____

Occupation: _____ **Retired:** ____ **No** ____ **Yes (if yes) When** _____

Primary language spoken in the home: _____ **Other language spoken in the home:** _____

Marital Status: ☐ **Single** ☐ **Married (Number)** ____ ☐ **Committed relationship** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Number and ages of children: _____

Are children living with the patient ☐ **Yes** ☐ **No** **How many?** _____

Patient lives: ☐ **With spouse or partner/family** ☐ **Alone with assistance** ☐ **Alone with no assistance**

Senior living environment ☐ **Assisted Living** ☐ **Nursing Home** ☐ **Other:** _____

Emergency Contact Name: _____ **Phone** _____

Referral Information

Who referred you for a Neuropsychological evaluation? _____

Address of referral source: _____

Phone number of referral source: _____ **Fax number of referral source:** _____

A copy of your report will be sent to the referral source and a copy will be placed in your medical record.

Educational History

Highest grade completed? ☐ **Less than High School (** _____ **Grade)** ☐ **GED (Last Grade Completed** _____**)**

☐ **High School** ☐ **Associate's Degree** ☐ **Bachelor's Degree** ☐ **Graduate Degree (Specify:** _____**)**

Identified learning disabilities during school years? Yes No If yes, please describe: _____

_____

Special education? ☐ **Yes** ☐ **No If yes, for what reason?** _____

Any concern about possible school difficulties that were not identified? ☐ **Yes** ☐ **No If yes, describe:**_____

_____

Was the patient ever held back in school? ☐ **Yes** ☐ **No What grade/s?** _____**Why?** _____

_____

Current Concerns

Please describe the reason you/the patient was referred to our office:

Please mark any of the following difficulties you/patient experience/s on a day-to-day basis:
* Please note how long ago symptom started (6 months, 1 year, 2 years, etc.) on line provided after symptom

☐ Memory: things that happened recently __
☐ Memory: Things from long ago _____
☐ Memory: Names of ____friends ____ family _____
☐ Remembering recent conversations _____
☐ Loosing things more frequently _____
☐ Asking the same question over and over _____
☐ Remembering appointments _____
☐ Remembering the _____ date _____ day of week _____
☐ Remembering to take medication on time _____
☐ Recalling names of common objects _____
☐ Loss of interest and motivation _____
☐ Difficulty learning new things _____
☐ Difficulty with concentration or paying attention _____
☐ Personality changes (less patient, nicer, nastier, friendlier, eating more sweets, aloof, messy, not motivated) _____
☐ Emotional changes (irritable, sad, up and down, etc.) _____

☐ Deciding what is most important _____
☐ Planning (family meal, trip, project) _____
☐ Making good decisions _____
☐ Following a a book or TV program/Movie _____
☐ Understanding what people are saying _____
☐ Harder to find the right words while talking _____
☐ Difficulty talking (slurring of words, mumbling) _____
☐ Forgetting how to operate something that you knew in the past _____
☐ Writing difficulty (change over time) _____
☐ Reading difficulty (slowed, or ceased reading) _____
☐ Math (balancing checkbook) _____
☐ Swallowing or choking _____
☐ Returning to a task after being interrupted _____
☐ Becoming preoccupied with things _____

Problems in the following areas and DURATION (6 months, etc.): * Please check ALL of the problems observed

☐ Personal hygiene (bathing, hair, shaving, clothing, etc) ____
☐ Less safety awareness _____
☐ Cooking (leaving stove on, ingredients, etc) _____
☐ Paying bills or managing finances_____
☐ Performing household/yard chores _____

☐ Driving (getting lost, judgment, fender benders) _____
☐ Independent shopping _____
☐ Social skills (rude, inappropriate, quiet, etc) _____
☐ Decreased involvement in hobbies _____
☐ Ability to work _____

What year did you/the patient first notice problems? _____ What was your earliest symptom/change?

What are you hoping to achieve with this evaluation?

Will any procedures that will be conducted at our offices be part of an ongoing or expected legal case or disability issues, and if so, please describe:

Services/Interventions Sought Previously for this Problem

☐ Medical Evaluation (Doctor) ☐ Neuropsychological Assessment ☐ Psychiatrist ☐ Neurological Exam

☐ Medication ☐ Counseling or Therapy ☐ Speech Therapy ☐ MRI/CT/EEG

☐ Results:

Has the patient had any of the following forms of psychological treatment? If so, how long did it last?

Individual psychotherapy ☐ Yes ☐ No Duration and date of therapy? _____

Inpatient mental health treatment ☐ Yes ☐ No Duration and date of placement? _____

Suicide Attempts? ☐ Yes ☐ No How many _____ When? _____ Method _____

Is there current depression, anxiety, panic attacks, etc.? Please provide specific details:

Significant Stressors

Have there been any major changes within the family life or the patient's living situation that have affected the patient's functioning (e.g., deaths, moves, divorces, loss of job, etc)? ↑No ↑Yes (describe below)

Medical/Health History

Patient's primary physician_____ Phone number _____

Vision problem? ☐ Yes ☐ No Hearing problem? ☐ Yes ☐ No

□ Difficulty swallowing ☐ Drooling ☐ Gagging ☐ Choking ☐ Difficulty Walking ☐ Dropping things?

Appetite concerns? ☐ Normal ☐ Decreased ☐ Increased Weight loss (lbs)_____ Weight gain (lbs)_____

Balance problems? ☐ Yes ☐ No **How many falls:**_____

Weakness? ☐ Yes ☐ No **Where:**_____

Tremors/Shaking? ☐ Yes ☐ No **Body Part:**_____ **How Long?**_____

Hearing or seeing things that are not there ☐ Yes ☐ No **How long?**_____ **How often?**_____

Does the patient have problems falling asleep? ☐ Yes ☐ No

Does the patient wake up in the middle of the night? ☐ Yes ☐ No **If Yes, how many times per night typically?**_____

Are there any current concerns related to toileting accidents or bowel/bladder incontinence ☐ Yes ☐ No

If yes, please describe: _____

Medication History: (Use back of form if there is not enough room)

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

Medical History: (Use back of form if necessary)

Medical Problem	Date of Diagnosis	Description of problem. Please write on the back of this form if necessary

Surgeries: Age: _____ Reason: _____ Where: _____

Surgeries: Age: _____ Reason: _____ Where: _____

Hospitalizations: Age: _____ Reason: _____ Where: _____

Details _____

Major accidents or injuries: Age: _____ Type (head, abdomen, fracture, etc.) _____

Details

_____

Major accidents or injuries: Age: _____ Type (head, abdomen, fracture, etc.) _____

Details _____

Has the patient ever been knocked unconscious? ☐ **Yes** ☐ **No If yes, details and how long:** _____

Has the patient ever been exposed to any toxic chemicals ☐ **Yes** ☐ **No If yes, please explain:** _____

Has the patient had any of the following tests or evaluations?

	Yes	Date (month/ year)	Where	Results
Neurological Evaluation				Normal Abnormal Don't Know
CT scan of head				Normal Abnormal Don't Know
MRI scan of head				Normal Abnormal Don't Know
EEG				Normal Abnormal Don't Know
Audiology or hearing evaluation				Normal Abnormal Don't Know
Vision evaluation				Normal Abnormal Don't Know
Genetic Testing				Normal Abnormal Don't Know
Other laboratory tests				Normal Abnormal Don't Know

Family Medical History

Have any of the patient's family members had the following problems/disorders? Please specify the family member's relationship to the patient and whether the relationship is on the maternal (m) or paternal (p) side. Example: aunt (p) = aunt on the father's side.

	Family Member(s) Relation to Patient		Family Member(s) Relation to Patient
Stroke/Aneurysm	_____	Alcohol/ Drug abuse	_____
Anxiety	_____	Attention Deficit Disorder	_____
Autism/ Asperger's	_____	Bipolar disorder	_____

Birth defect _____ Cancer _____
Dementia _____ Memory Problems _____
Depression _____ Diabetes _____
Genetic disorder _____ Heart Disease _____
Parkinson's Disease _____ Intellectual Disability _____
Migraine headaches _____ Multiple sclerosis _____
Essential Tremor _____ Obsessive-Compulsive Disorder _____
Schizophrenia _____ Seizures or epilepsy _____
Academic Problems _____ Tics/ Tourette's Disorder _____
Other (specify): _____

Personal/Social Information

Has there been a decline in the patient's ability to do things that were once quite easy? (home repairs, cooking, sewing, auto maintenance, dressing, showering, working, driving, paying bills, shopping, cleaning, etc.)

What are the patient's main hobbies and interests?

How often is the patient participating in these activities?

Occupational History

Present or Most Recent Job (Include job titles, description of work, years employed): _____

Previous Jobs (job titles, description of work, years employed, and reason for change):

Any problems encountered in your current work activities? _____

Substance Use

How many alcoholic drinks a day/week does the patient consume and what kind? _____

At what age did the patient start drinking? _____ When was the patient's last drink of alcohol? _____
Has the patient ever experienced problems due to alcohol consumption, and if so, please describe: _____

Is there a family problem of alcohol abuse, and if so, please describe: _____

Has the patient ever used any of the following:
Marijuana Heroine Cocaine/Crack LSD Ecstasy Methamphetamines Hallucinogens
Other non-prescribed drugs, please describe: _____

If the patient has used any of the above, please indicate frequency of use, age of first use, and describe any treatment:

Has the patient received any treatment for alcohol or other substance use? ☐ Yes ☐ No If yes, please describe: _____

_____

Does the patient smoke cigarettes, pipes, cigars, or chew tobacco? ☐ Yes ☐ No
If yes, please describe frequency and amount: _____

Legal

Has the patient had any involvement with the legal system? ☐ Yes ☐ No

Is the patient currently on parole? ☐ Yes ☐ No Is the patient currently on probation? ☐ Yes ☐ No

Is there a lawsuit or disability claim or Worker's Compensation claim in relation to the problems for which you are being seen? If yes, explain in detail below. ☐ Yes ☐ No
Describe case or claim (use back if necessary):

Name of Attorney representing you: _____

Do you currently have a lawyer who you are discussing *possible* litigation with? ☐ Yes ☐ No

Any previous Worker's Compensation history? ☐ Yes ☐ No If yes to either question, provide details: _____

_____

_____

_____

Is the patient currently receiving disability? ☐ Yes ☐ No If yes, specify condition: _____
Is the patient currently applying for disability? ☐ Yes ☐ No If yes, specify condition: _____

Other Concerns

Please use this space to write in any additional concerns that were not addressed in this questionnaire.

The information I have provided is true and correct to the best of my knowledge:

_____ _____
Patient Signature (or POA) Date