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PATIENT REGISTRATION AND HISTORY: *ADULT*

Date: _____

Referred by: _____

Name: _____ Other names used: _____

DOB: _____ Gender: ___ M or ___ F Marital Status: _____

Address: _____
(Street) *(City)* *(Zip)*

Phone: Home: _____ Cell: _____ Other: _____

Email Address: _____

Ethnicity/Race: _____ Religion: _____

Primary Language: _____ Secondary Language: _____

Employment/School: _____ Title: _____

Hand used for writing: Left or Right (circle answer) Glasses or hearing aids: _____

Medical/psychological diagnosis, physician, and date (if any):

1) _____ 3) _____

2) _____ 4) _____

Briefly describe the problems or symptoms and when they began: _____

_____

What specific questions would you like answered?

1) _____

2) _____

3) _____

Health Insurance: _____ Subscriber Name: _____

Subscriber ID #:_____ Subscriber DOB: _____

This form was completed by: Patient: ___Y or ___N Other: _____
If not completed by the patient, please provide the following information:

Name: _____ Address: _____

Phone: _____ Relation: _____

Family History

The following questions deal with your BIOLOGICAL mother, father, brothers, and sister:

Mother

What is your mother's name (including maiden name): _____

Is she alive? ___ Yes ___ No If not, list cause of death: _____

Mother's occupation: _____

Mother's level of education obtained: _____

Mother's hobbies: _____

Does your mother have a known/suspected learning disability? ___ Yes ___ No

Briefly describe your mother's health history: _____

_____

Father

What is your father's name: _____

Is he alive? ___ Yes ___ No If not, list cause of death: _____

Father's occupation: _____

Father's level of education obtained: _____

Father's hobbies: _____

Does your father have a known/suspected learning disability? ___ Yes ___ No

Briefly describe your father's health history: _____

_____

When you were born, what was your mother's age? ___ Father's age? ___

How many brothers do you have? ___ How many sisters do you have? ___

Where are you in the birth order? _____

Are there unusual issues associated with any of your siblings? ___ Yes ___ No

If yes, please describe: _____

Family Life

Were you adopted? _____ No _____ Yes At what age? _____

Were you fostered? _____ No _____ Yes At what age? _____

Please list all household members currently living in your home and their relation to you:

Early History

Were you born: ___ On time ___ Late ___ Prematurely (# of weeks ___)

Weight at birth: ___ lbs ___ ozs

Where were you born? _____

Were there any issues associated with your birth (e.g. oxygen deprivation, unusual birth position, etc.) or the period immediately following the birth (e.g. need for oxygen, special equipment used, convulsions, illness, etc.)? ___ No ___ Yes, describe:

_____

_____

Check all that applied to your mother while she was pregnant with you:

___ Accident ___ Alcohol use

___ Cigarette smoking ___ Drug use

___ Illness ___ Poor nutrition

___ Psychological problems ___ Other issues: _____

List all the medications (prescription or over the counter) your mother took while pregnant:

_____

During her pregnancy, did your mother live near a polluted area (toxic waste dump) or hazardous area (nuclear plant, industrial area, pesticide sprayed area, etc.)? ___ Yes ___ No

If yes, describe: _____

Rate your development progress as it has been reported:

	Early	*Average*	*Late*	*(what age developed)*
Walking	_____	_____	_____	_____
Language	_____	_____	_____	_____
Toilet training	_____	_____	_____	_____
Overall development:	_____	_____	_____	_____

Medical History

Check all that currently apply:

___ AIDS, ARC or HIV ___ Addiction to drugs ___ Alcohol problems

___ Allergies ___ Blood disorder ___ Diabetes

___ Brain disease or infection ___ Cancer/chemotherapy ___ Heart disease

___ Hazardous substance exp ___ Kidney disease ___ Hypertnsion

___ Liver disease ___ Lung disease ___ Stroke or CVA ___

Psychiatric issues Other: _____

Do you have epilepsy or a seizure disorder? ___ Yes ___ No

If yes, check the one you have been diagnosed with:

Partial	*Generalized*
___ Simple partial (Jacksonian)	___ Absence (petit mal)
___ Complex partial (Psychomotor)	___ Myoclonic
___ Partial evolving into generalized	___ Clonic
___ Unclassified type	___ Tonic
___ Don't know which type	___ Tonic-clonic (Grand mal)
	___ Atonic

Please describe: _____

Describe all hospitalizations (include purpose, length of stay, and location): _____

_____

_____

As a child, did you have any of the following conditions? (*Check all that apply*)

_____ Attention problems	_____ Head injury	_____ Speech delay
_____ Hearing problems	_____ Hyperactivity	_____ Clumsiness
_____ Frequent ear infections	_____ Vision problems	_____ Learning delay
_____ Development delay	_____ Muscle tightness or weakness	
_____ Other problems: _____		

List any medications you currently take (prescription or over the counter):

Medication	Dosage	Frequency Taken	Date began Taking	Prescribed by	Prescribed for

Medical Informaiton

Who is your primary care physician:

Name: _____ Clinic: _____

Address: _____ Phone: _____

Updated immunizations and examinations: ___ Yes ___ No

Do you have a treating psychologist/psychiatrist?

Name: _____ Clinic: _____

Address: _____ Phone: _____

Start date of therapy: _____ Frequency of therapy: _____

Reason for therapy: _____

Have you had a previous psychological/neuropsychological evaluation? ___ Yes ___ No

If yes, please list the name and address of the psychologist and date administered:

_____

* Please provide a copy of the report at your intake appointment

Medical Testing

Check all the medical tests that recently (within the past year) have been done and report any abnormal findings:

Please also state the name of the physician who ordered or did the test for you.

___ Angiography _____

___ Blood Work _____

___ CT scan _____

___ EEG _____

___ MRI/FMRI _____

___ PET/SPECT scan _____

___ Other test(s) _____

Please check all that existed in close biological family members (parents, siblings, grandparents, aunts, uncles, etc.). Note who it was and describe the issue where indicated:

___ Epilepsy or seizures _____

___ Learning disabilities _____

___ Left-handedness _____

___ Mental retardation _____

___ Speech or language disorder(s) _____

Neurological or Psychiatric Disorders

___ Alzheimer's disease _____

___ Bipolar disorder _____

___ Depression _____

___ Personality disorder _____

___ Schizophrenia _____

___ Other psychiatric disorders _____

___ Other major disease or disorder _____

Substance Use History

Alcohol

I drink alcohol: ___ Rarely or never ___ 3-5 days per week

___ 1-2 days per week ___ Daily

I use drink but stopped (date stopped): _____

I started drinking regularly at age: ___ Preferred type of drinks: _____

My last drink was: ___ less than 24 hours ago ___ 24-48 hours ago ___ over 48 hours ago

Check all that apply:

___ I can drink more than most people my age and size before I feel drunk

___ I sometimes get into trouble after drinking

___ I sometimes blackout during or after drinking

Drugs

Please check all drugs you are currently using or have used in the past:

	Presently using	*Used in the past*
___ Amphetamines	___	___
___ Barbiturates	___	___
___ Cocaine or crack	___	___
___ Hallucinogens	___	___
___ Marijuana	___	___
___ Opiates/Narcotics (Heroin)	___	___
___ PCP	___	___

List any other drugs, including designer and "non-harmful" of "non-addictive" drugs: _____

_____

Do you consider yourself dependent on any of the above drug(s)? ___ Yes ___ No

Do you think you are dependent on any prescription drug(s)? ___ Yes ___ No

Check all that apply:

___ I have gone though drug withdrawal

___ I have used IV drugs

___ I have been in drug treatment

Personal History

Education

Highest grade or degree earned: _____

Schools attended: _____

Describe your performance as a student? ___ A & B's ___ B & C's ___ C & D's ___ D & F's

Please provide any additional/helpful comments about your academic performance:

_____

What was your best subject? _____ Weakest? _____

Were you ever held back a grade? ___ Yes ___ No If yes, which grade? _____

Were you in special classes/received special education services? ___ Yes ___ No

Recreation

Briefly list the types of recreation you enjoy: _____

Military

Branch: _____ Discharge rank: _____ Type of discharge: _____

Major duties: _____

List any injuries sustained: _____

Were you exposed to any dangerous or unusual substances during your services (Agent Orange, radiation, etc.)? If yes, list: _____

Occupational History

Current job title: _____How long at job? _____

Current job responsibilities: _____

Prior jobs and time spent at them: _____

_____

At any time on a job, were you exposed to toxic, hazardous, noxious or other dangerous or unusual substances? (ex. Lead, mercury, radiation, solvents, pesticides, chemicals, etc.)?

___ Yes ___ No If yes, list: _____

SYMPTOM SURVEY

Please place a check on the line next to each applicable symptom. Check the side marked "NEW" if the symptom has been present for 6 months or less. Check the side marked "OLD" if the symptom has been present for more than 6 months.

Problem Solving

NEW	OLD	
_____	_____	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
_____	_____	Difficulty verbally describing the steps involved in doing something
_____	_____	Difficulty changing a plan or activity when necessary
_____	_____	Difficulty completing an activity in a reasonable amount of time
_____	_____	Difficulty doing more than one thing at a time
_____	_____	Difficulty switching from one activity to another activity
_____	_____	Easily frustrated
_____	_____	Other problem solving difficulties: _____

Speech, Language and Math Skills

NEW	OLD	
_____	_____	Difficulty finding the right words 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 (checkbook balancing, making change, etc.)
_____	_____	Difficulty understanding what was read
_____	_____	Difficulty spelling
_____	_____	Other speech, language, or math problems: _____

Nonverbal Skills

NEW	OLD	
_____	_____	Difficulty telling right from left
_____	_____	Difficulty doing things that I should automatically be able to do (brushing teeth, etc.)
_____	_____	Problems 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 things on one side of my body (right _____/left _____)
_____	_____	Decline in my musical abilities
_____	_____	Slow reaction time
_____	_____	Other nonverbal issues: _____

Concentration and Awareness

NEW	OLD	
_____	_____	Highly distractible
_____	_____	Lose my train of thought easily
_____	_____	Problems concentrating
_____	_____	Become easily confused or disoriented
_____	_____	Blackout spells (fainting)
_____	_____	My mind goes blank
_____	_____	Don't feel very alert or aware of things
_____	_____	Other concentration or awareness issues: _____

Memory

NEW	OLD	
_____	_____	Forgetting where I leave things (keys, books, etc.)
_____	_____	Forgetting names
_____	_____	Forgetting what I should be doing
_____	_____	Forgetting where I am or where I am going
_____	_____	Forgetting events that happened quite recently (such as my last meal)
_____	_____	Forgetting events that happened a long time ago (months/years)
_____	_____	Need someone to give me a hint so I can remember things
_____	_____	Forgetting the order of things (when cooking, etc.)
_____	_____	Forgetting facts but I can 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 issues: _____

Motor Coordination

NEW	OLD		*Right*	*Left*	*Both*
_____	_____	Fine motor control problems	_____	_____	_____
_____	_____	Weakness on one side of my body	_____	_____	_____
_____	_____	Difficulty walking or bumping into things	_____	_____	_____
_____	_____	Tremor or weakness	_____	_____	_____
_____	_____	Muscle tics 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 issues: _____			

Sensory

NEW	OLD	
_____	_____	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 objects 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 issues: _____

Physical

NEW	OLD	
_____	_____	Headaches
_____	_____	Dizziness
_____	_____	Nausea or vomiting
_____	_____	Urinary incontinence
_____	_____	Loss of bowel control
_____	_____	Excessive tiredness
_____	_____	Other physical issues: _____

Behavior

Check all that apply to you in the past 6 months:	Severity Level:	*Mild*	*Moderate*	*Severe*
_____ Sadness or depression		_____	_____	_____
_____ Anxiety or nervousness		_____	_____	_____
_____ Sleeping issues (Falling asleep: ___ Staying asleep: ___)		_____	_____	_____
_____ Becoming angry more easily		_____	_____	_____
_____ Euphoria (feeling on top of the world)				
_____ Much more emotional (cry more easily)				
_____ Feel as if I just don't care anymore				
_____ Doing things automatically (without awareness)				
_____ Less inhibited (do things I would not do before)				
_____ Difficulty being spontaneous				
_____ Change in eating habits				
_____ Change in interest in sex				
_____ Other recent changes in behavior/personality: _____				

Check the answer that best fits.

Overall, my symptoms have developed:	___ Slowly	___ Quickly
My symptoms occur:	___ Occasionally	___ Often
Over the past 6 months my symptoms have:	___ Stayed the same	___ Worsened