ADULT NEUROBEHAVIORAL HISTORY FORM

_____

Patient Name

_____

Date Completed

_____

Completed By

It is very important to understand an individual's 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 complete, accurate responses will greatly help in understanding the symptoms you may be experiencing. This will also help to identify the most appropriate treatment plans and strategies.

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

Please complete this form and bring it with you to your appointment.

I. DEMOGRAPHIC & REFERRAL INFORMATION

Full Legal Name:_____ Date of Birth:_____ Sex: ☐M ☐F

Mailing Address: _____

Home Ph:_____ Work Ph:_____ Cell Ph: _____

Email Address:_____ SSN:_____

Referred By:_____ Phone:_____

What is your understanding of the reason for referral? _____

_____

Give a brief history of your symptoms leading to this referral, (i.e. onset to present):

_____

_____

On the scale below, how would you rate the severity of your symptoms connected to this referral?

☐Mildly Upsetting ☐Moderately ☐Severe ☐Very Severe ☐Extremely Severe ☐Totally Incapacitating

II. FAMILY INFORMATION

Marital Status: ☐Single ☐Married ☐Divorced ☐Remarried ☐Widowed ☐Life Partner
Please list marriages and/or significant others, current and previous, with dates: _____

_____

_____

Moves in childhood:_____ #Moves in Adulthood: _____
Religious Preference:_____ How often do you attend service?_____

CHILDREN IN FAMILY, (please list biological, step and/or adopted)

NAME	AGE	SEX	GRADE	HOW IS SCHOOL GOING

OTHER PEOPLE IN THE HOUSEHOLD

NAME	AGE	SEX	EDUCATION	RELATIONSHIP TO PATIENT

	PARENTS NAME	AGE	OCCUPATION	RACE	DECEASED
Mother					Y N
Father					Y N
Stepmother					Y N
Stepfather					Y N
Legal Guardian					Y N

SIBLINGS

NAME	AGE	SEX	EDUCATION (IN YRS)	DECEASED
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N

II. DEVELOPMENTAL HISTORY

Place of Birth:_____Birth weight: (if known)_____Birth Length: _____
Complications at birth?_____
Did your mother smoke, drink, or use drugs during pregnancy? ☐Yes ☐No
If yes, what and how much?_____
As a child did you have any of the following?

☐Premature Birth	☐Meningitis	☐High Fevers
☐Low Birth Weight	☐Seizures	☐Birth Defects
☐Birth Complications/Injury	☐Recurrent Ear Infections	☐Hearing Problems
☐Vision problems	☐Asthma	☐Bed-wetting
☐Other_____		

Which is your dominant hand? ☐R ☐L ☐Ambidextrous
Have you:
☐Been physically assaulted
By whom_____For how long/how many times_____
Treated for_____
☐Been sexually abused
By whom_____For how long/how many times_____
Treated for_____

III. FAMILY HISTORY

ANY FAMILY MEMBERS WITH THE FOLLOWING PROBLEMS?
(Family defined as brothers, sisters, parents, grandparents, aunts, and uncles).

Condition	Relation
Learning Problems:	_____
Depression:	_____
Alcoholism/Drug Addition:	_____
Epilepsy:	_____
Mental Retardation:	_____
Trouble with the law:	_____
Hyperactivity:	_____
Anxious or perfectionist:	_____
Speech or hearing problems:	_____
TIC behaviors or nervous habits:	_____
Psychiatric hospitalization:	_____

Other behavior or emotional problems: _____

Family history of left-handedness? _____

Any major health problems diagnosed in your immediate or extended family (e.g. diabetes, heart disease, high blood pressure, stroke)?

_____

IV. HEALTHCARE HISTORY

Primary Care Physician: _____ Phone:_____
Do you want us to send report of this assessment? ☐Yes ☐No

Do you see a dentist? ☐Yes ☐No Are there dental problems? ☐Yes ☐No

Do you regularly see any other physician/therapist than your primary physician ? ☐Yes ☐No
If yes, Who?_____

Have you ever been treated for any psychiatric or behavioral disorder (e.g., ADHD, substance abuse, depression)? ☐Yes ☐No If yes, please list the disorder, dates, and any medication prescribed:

_____

_____

Have you ever had any of the following?

☐Head Injury (TBI)
☐Automobile Accident(s)
☐Neurological Disease or Injury
☐Heart Problems
☐Near Drowning
☐Alcohol/Substance Abuse
☐High Blood Pressure
☐Heart disease
☐Cancer
☐Blood disorder
☐Visual Problems
☐Serious Infection
☐Meningitis
☐Encephalitis
☐Diabetes
☐Liver or Kidney disease
☐Stroke
☐Prescription Drug Abuse
☐Hospitalizations
☐Poisoning
☐Toxic Exposures
☐Headaches
☐Paralysis
☐Deafness/hearing loss
☐Back/Neck injury
☐"Nervous Breakdown"
☐High Fever
☐Seizures
☐Other _____

Medications you currently take:

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

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 you stopped smoking? _____

Do you currently drink alcohol? ☐Yes ☐No Number of drinks per occasion _____
If no, have you ever drank? ☐Yes ☐No
Has your alcohol use 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:

_____

Please check any you have experienced or are experiencing now:

☐Headaches	☐Dizziness	☐Fainting Spells
☐Rapid Heart Beat	☐Stomach Trouble	☐No Appetite
☐Bowel Disturbances	☐Fatigue	☐Insomnia
☐Nightmares	☐Can't Stay Asleep	☐Overeating
☐Feel Tense or Anxious	☐Feel panicky	☐Tremors/Shaky
☐Depressed	☐Suicidal	☐Unusually Extreme Temper
☐Unable to Relax	☐Sexual Problems	☐Shy with People
☐Don't Like Weekends/Vacations	☐Over Ambitious	☐Can't Make Decisions
☐Can't Make Friends	☐Inferiority problems	☐Home Conditions Uncomfortable
☐Can't Keep a Job	☐Memory problems	☐Unable to Have a Good Time
☐Financial Problems	☐Concentration Difficulties	☐Other
☐Sensitive to Light	☐Sensitive to Loud Noise	

V. 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:_____ Are school records available? _____
Extra-Curricular activities: _____

Education support required?

☐Started school late	☐Held back/repeated grade	☐Behavior problems
☐Resource/Spec. Ed	☐Underachiever	☐Learning Problems
☐Tutoring	☐Poor Motivation	☐Other: _____
☐Remedial Classes	☐Attention/Concentration Problems	

Please explain any of the above:

_____

_____

What, if anything, detracted from a successful school experience?

_____

Best and worst academic areas?

_____

Trade School/Community College:_____Academic Focus: _____
Years attended:_____Estimated GPA:_____Certification/Diploma? _____
List apprenticeships, courses, other training:

_____

University/College:_____Major/Minor: _____
Years Attended:_____Estimated GPA:_____Certification/Diploma? _____

Graduate School:_____Graduate area of study: _____
Years Attended:_____Degree/date:_____Estimated GPA: _____

VI. PERSONAL HISTORY

Current Occupation: _____

Current Employer:_____How Long? _____

Previous Employer:_____Position:_____How Long? _____

Previous Employer:_____Position:_____How Long? _____

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:

_____

_____

Hobbies:_____
Recreational Activities: _____
Particular Areas of Interest: _____

VII. MILITARY EXPERIENCE

Branch:_____Highest Rank: _____
Specialty Areas: _____

VIII. DETAIL OF ACCIDENT/INJURY (IF APPLICABLE)

Date of accident/injury:_____
Details of accident/injury:_____
Loss of consciousness? ☐Yes ☐No Estimated length of unconsciousness? _____
Specific injuries: _____

_____

Which, if any, of the symptoms below have you experienced since your injury? If they were present before the injury but changed please explain below:

☐Nausea
☐Vomiting
☐Ringing in the ears
☐Blurred vision
☐Headache
☐Aggression
☐Decreased sexual drive
☐Fainting/blackouts
☐Memory Problems
☐Depression
☐Pain in chest
☐Anxiety
☐Decreased attention/concentration
☐Fatigue easily
☐Poor sleep
☐Decreased energy
☐Weight loss/gain
☐Difficulty with crowds
☐Mood swings
☐Hallucinations

Changes in:

☐Speech/Language ☐Reading ☐Math Skills ☐Thinking
☐Sense of Smell ☐Sense of Taste ☐Anger ☐Stress Tolerance
☐Frustration Tolerance