DEPARTMENT OF NEUROPSYCHOLOGY
32 W. Gore St., 5th Floor, Orlando, FL 32806
Tel: 321.841.3820 *Fax:* 321.843.6836
Robert E. Cohen, PsyD, Clinical Director
Elizabeth Morgan, PhD **Maria M. Coiro, PhD**
Kenia Rodriguez-Spengler, PsyD **Karen Mikolic, PhD**

Adult Neuropsychological History

Patient's name _____ DOB_____ Age_____ Sex _____
Home address _____ Phone (Home) _____
_____ (Work) _____
Primary Language_____Secondary Language_____
Education/Degree_____ Current job title _____
Hand used for writing: Right hand_____Left hand_____ (please check one)
Foot used for kicking: Right foot_____Left foot_____ (please check one)
Who referred you to this evaluation? _____
Briefly describe problem/diagnosis that brings you here
_____
_____
Any specific question(s) you would like answered by this evaluation?
(1)_____
(2)_____
(3)_____

Are you medically disabled or applying for medical disability? Yes_____No_____
Is there any current or pending litigation in which this evaluation will be used? Yes_____No_____
Have you had a prior neuropsychological evaluation? Yes_____No_____
If yes, complete this information: Name of Psychologist: _____
Address_____
Phone_____Fax_____
Date of and reason for the evaluation: _____
Findings of evaluation?_____

List medications you currently take (over the counter, prescription, supplements). Attach extra page if needed.

Medications	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This form has been completed by: _____
If not completed by patient, please provide the following information:
Relationship to patient_____
Phone number where you may be reached if needed: _____

DEPARTMENT OF NEUROPSYCHOLOGY
32 W. Gore St., 5th Floor, Orlando, FL 32806
Tel: 321.841.3820 *Fax:* 321.843.6836
Robert E. Cohen, PsyD, Clinical Director
Elizabeth Morgan, PhD **Maria M. Coiro, PhD**
Kenia Rodriguez-Spengler, PsyD **Karen Mikolic, PhD**

Symptom Survey

Please check each symptom that **currently** applies. These will be discussed further at your appointment.

Problem Solving

__ Takes longer to figure out how to do new things
__ Difficulty planning ahead
__ Difficulty figuring out problems that most other people can do
__ Slowed thinking
__ Difficulty doing things in the right order
__ Difficulty verbally describing the steps involved in doing something
__ Takes longer to complete an activity
__ Difficulty doing more than one thing at a time
__ Difficulty switching from one activity to another activity

Speech, Language, and Math Skills

__ Problems finding the right word to say
__ Trouble understanding what others are saying
__ Difficulty speaking
__ Difficulty staying with one idea
__ Problems writing letters or words (not due to motor problems)
__ Slurred speech
__ Odd or unusual speech sounds
__ Difficulty with math (e.g. balancing a checkbook, making change, etc)
__ Trouble understanding what I read

Nonverbal Skills

__ Difficulty telling right from left
__ Trouble doing things I should automatically be able to do (e.g. brushing teeth)
__ Problems drawing or copying
__ Problems finding my way around places I have been before
__ Difficulty recognizing objects or people
__ Feeling that parts of my body do not belong to me
__ Unaware of things on one side of my body: Right side_____Left side_____
__ Decline in my musical abilities
__ Slowed reaction time

Concentration and Awareness

__ Lose my train of thought easily/my mind goes blank
__ Problems concentrating
__ Become easily confused or disoriented
__ Unable to keep track of time (e.g. time of day, season, year)
__ Blackout spells (fainting)
__ Aura (strange feelings)

DEPARTMENT OF NEUROPSYCHOLOGY
32 W. Gore St., 5th Floor, Orlando, FL 32806
Tel: 321.841.3820 *Fax:* 321.843.6836
Robert E. Cohen, PsyD, Clinical Director
Elizabeth Morgan, PhD **Maria M. Coiro, PhD**
Kenia Rodriguez-Spengler, PsyD **Karen Mikolic, PhD**

Memory

__ Forget where I leave things (keys, gloves, etc)
__ Forget names
__ Forget where I am or where I am going
__ Forget events that happened quite recently (e.g. my last meal)
__ Forget events that happened long ago
__ Rely more on notes or hints to remember things
__ Forget the order of things (e.g. when cooking)
__ Forget facts, but can remember how to do things
__ Forget how to do things but can remember facts
__ Frequently forget things I am supposed to do, such as appointments

Motor and Coordination

	If present, check the side this occurs on:		
	Right	Left	Both
__ Fine motor problems (trouble holding a pen, using a key, etc.)	_____	_____	_____
__ Weakness on one side of my body	_____	_____	_____
__ Dropping things	_____	_____	_____
__ Tremor or shakiness	_____	_____	_____

__ Muscle tics, jerkiness, or strange movements
__ Handwriting is smaller/larger than it used to be
__ Walking more slowly
__ Feeling stiff
__ Balance problems
__ Difficulty starting to move
__ Muscles tire quickly
__ Clumsy/often bumping into things

Sensory Problems

	If present, check the side this occurs on:		
	Right	Left	Both
__ Loss of feeling or numbness	_____	_____	_____
__ Tingling or strange skin sensations	_____	_____	_____
__ Difficulty telling hot from cold	_____	_____	_____
__ Problems seeing on one side	_____	_____	_____
__ Blurred or double vision	_____	_____	_____
__ Blank spots in vision	_____	_____	_____
__ Brief periods of blindness	_____	_____	_____
__ See “stars” or flashes of light	_____	_____	_____

__ Difficulty seeing things
__ Hearing problems
__ Ringing in ears or hearing strange sounds
__ Difficulty smelling or tasting

DEPARTMENT OF NEUROPSYCHOLOGY
32 W. Gore St., 5th Floor, Orlando, FL 32806
Tel: 321.841.3820 *Fax:* 321.843.6836
Robert E. Cohen, PsyD, Clinical Director
Elizabeth Morgan, PhD **Maria M. Coiro, PhD**
Kenia Rodriguez-Spengler, PsyD **Karen Mikolic, PhD**

Physical

__ Headaches
__ Dizziness
__ Imbalance
__ Falls
__ Nausea or vomiting
__ Need to go to the bathroom more often
__ Constipation
__ Urinary incontinence
__ Loss of bowel control
__ Excessive tiredness
__ Other Pain

Mood/Behavior (Check all that apply to you in the past 6 months.) If present, rate how much of a problem it has been:

	Mild	Moderate	Severe
__ Sadness or depression	_____	_____	_____
__ Anxiety or nervousness	_____	_____	_____
__ Stress	_____	_____	_____
__ Sleeping problems (Falling asleep_____ Staying asleep_____)	_____	_____	_____

__ Become angry more easily
__ Easily frustrated
__ Euphoria (feeling on top of the world)
__ Much more emotional (e.g. cry more easily)
__ Feeling as if I just don't care anymore
__ Less inhibited (do/say things I would not before)
__ Difficulty being spontaneous
__ Change in eating habits
__ Change in interest in sex
__ Change in personality

Overall, when did your symptoms begin? _____

PSYCHIATRIC/PSYCHOLOGICAL HISTORY – Past/Current Treatment Provider_____

Do you have a history of psychiatric hospitalization (s)? _____ if so, when? _____for how long?_____

Do you have a psychiatric/psychological diagnosis? _____if so what?_____
Are you currently or have you ever been treated for this disorder?_____ medication_____therapy_____
Please list medication (s)_____
Have you ever tried to commit suicide? _____if so, how many times?_____
Do you have a history of visual or auditory hallucinations or strange/bizarre thoughts?_____
Do you have a history of obsessive or compulsive behavior?_____
Do you have a history of addictive behavior? (food, sex, drugs, other?)_____

DEPARTMENT OF NEUROPSYCHOLOGY
32 W. Gore St., 5th Floor, Orlando, FL 32806
Tel: 321.841.3820 *Fax:* 321.843.6836
Robert E. Cohen, PsyD, Clinical Director
Elizabeth Morgan, PhD **Maria M. Coiro, PhD**
Kenia Rodriguez-Spengler, PsyD **Karen Mikolic, PhD**

Medical and Developmental History (Complete all that you can for this section)

Adult Medical History (please check any that apply now or in the past)

__ AIDS, ARC, or HIV+
__ Allergies
__ Alzheimer's disease
__ Arteriosclerosis (artery disease)
__ Arthritis
__ Brain disease or infection
__ Cancer or chemotherapy
__ CVA, Stroke, and/or TIA
__ Dementia
__ Exposure to hazardous chemicals
__ Heart Attack
__ Heart Disease
__ Huntington's disease
__ Kidney disease
__ Liver disease
__ Lung (respiratory) disease, such as COPD
__ Meningitis
__ Multiple Sclerosis
__ Parkinson's disease
__ Polio
__ Psychiatric problems
__ Radiation exposure or therapy
__ Seizures/Epilepsy (Type) _____
__ Thyroid Disease
__ Venereal disease
__ Any other medical problems :_____

Please list all hospitalizations/surgeries you have had with the date(s) if possible:
a)_____
b)_____
c)_____
d)_____

Have you ever had an injury or blow to your head (with or without loss of consciousness)? Yes_____No____
If Yes, explain the circumstances and any problems you had afterwards _____
_____
_____

Have you ever been exposed to toxic, hazardous, noxious, or otherwise dangerous or unusual substances (e.g., lead, mercury, radiation, solvents, pesticides, chemicals, etc.)? If yes, please explain:
_____
_____

DEPARTMENT OF NEUROPSYCHOLOGY
32 W. Gore St., 5th Floor, Orlando, FL 32806
Tel: 321.841.3820 *Fax:* 321.843.6836
Robert E. Cohen, PsyD, Clinical Director
Elizabeth Morgan, PhD **Maria M. Coiro, PhD**
Kenia Rodriguez-Spengler, PsyD **Karen Mikolic, PhD**

Childhood History

You were born: _____On time _____Prematurely _____Late Birth weight _____lbs _____oz

Any problems associated with your birth (e.g. oxygen deprivation, unusual birth position) or the period immediately afterward (e.g. need for oxygen, special equipment used, convulsions, illness)? If yes, please explain.

_____

Rate your development, if you know, by checking one description for each area:

	Early	Average	Late
Walking	_____	_____	_____
Talking	_____	_____	_____
Toilet training	_____	_____	_____
Overall development	_____	_____	_____

Childhood Medical History (check all that apply)

____Allergies
____Asthma
____Attention problems
____Brain infection or disease
____Cancer
____Cerebral palsy
____Chicken pox
____Developmental delay
____Diabetes
____Encephalitis
____Epilepsy or seizures
____Fevers (104◦F or higher)
____Frequent Colds
____Frequent Ear Infections
____Head Injury
____Hearing Problems
____Heart problems
____Hyperactivity
____Immune system disease
____Kidney problems
____Learning Disability
____Lung (respiratory) problems
____Measles
____Meningitis
____Muscle tightness or weakness
____Oxygen deprivation
____Pneumonia
____Poisoning
____Polio
____Rheumatic fever
____Scarlet Fever
____Speech Problems
____Tuberculosis
____Venereal disease
____Vision problems
__ Exposure to lead or other toxins : _____

As a child, did you have an accident which required a hospital visit? Yes_____No_____
If Yes, please describe: _____

Please list any medications that you were regularly given to you as a child:

Medication:	Reason for the medication:
_____	_____
_____	_____
_____	_____
_____	_____

DEPARTMENT OF NEUROPSYCHOLOGY
32 W. Gore St., 5th Floor, Orlando, FL 32806
Tel: 321.841.3820 *Fax:* 321.843.6836
Robert E. Cohen, PsyD, Clinical Director
Elizabeth Morgan, PhD **Maria M. Coiro, PhD**
Kenia Rodriguez-Spengler, PsyD **Karen Mikolic, PhD**

Family History

Mother
Is she living? Yes_____ No_____ If deceased, what was the age and cause of death?_____
Mother's level of education:_____ Mother's occupation:_____

Father
Is he living? Yes_____ No_____ If deceased, what was the age and cause of death?_____
Father's level of education:_____ Father's occupation:_____

How many siblings do you have? _____brothers age(s) _____
_____sisters age(s) _____

How many children do you have? _____boys age(s)_____
_____girls age(s)_____

Please check any condition that existed in close biological family members (parents, children, brothers, sisters, grandparents, aunts, and uncles), note who it was, and describe the problem if needed.

Diagnosis	Who?
_____Alcoholism	_____
_____Alzheimer's disease or senility	_____
_____Bipolar illness (manic depression)	_____
_____Cancer	_____
_____Depression	_____
_____Epilepsy or seizures	_____
_____Heart attack/heart disease	_____
_____Huntington's disease	_____
_____Learning disability	_____
_____Multiple Sclerosis	_____
_____Parkinson's Disease	_____
_____Schizophrenia	_____
_____Speech or language disorder	_____
_____Stroke	_____
_____Other dementia	_____
_____Other neurologic or motor disorder	_____
_____Other medical disease or disorder	_____

DEPARTMENT OF NEUROPSYCHOLOGY
32 W. Gore St., 5th Floor, Orlando, FL 32806
Tel: 321.841.3820 *Fax:* 321.843.6836
Robert E. Cohen, PsyD, Clinical Director
Elizabeth Morgan, PhD **Maria M. Coiro, PhD**
Kenia Rodriguez-Spengler, PsyD **Karen Mikolic, PhD**

Personal History

Marital History

Current marital status: Married_____Single_____Divorced_____Widowed_____Separated_____
Years married to current spouse_____ Not married but living with someone Yes_____ No_____
Number of times married_____
Spouse's name_____ His/Her occupation_____
His/Her age _____ His/Her health status Excellent:_____ Good_____ Poor_____

Educational History

Highest grade or degree earned_____
How would you describe your usual performance as a student?

_____A & B _____C & D
_____B & C _____ D & F

Please provide any additional comments about your academic performance (i.e. AP classes, gifted classes, early graduation, etc.) _____

What was your best subject(s)?_____
Your weakest subjects(s)?_____

Did you repeat any grade? If yes, what grade(s)_____ Reason_____

Were you ever in any special education or remedial class(es) or did you receive special services? If yes, please indicate which grade(s)_____or age(s)_____ and what subject/class_____

Occupational History

Current or (if retired) most recent job title:_____

How long have you done/did you do this job?_____

Main job responsibilities:_____

Prior jobs (most recent first): _____
_____
_____

Military History

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

Major military duties:_____

DEPARTMENT OF NEUROPSYCHOLOGY
32 W. Gore St., 5th Floor, Orlando, FL 32806
Tel: 321.841.3820 *Fax:* 321.843.6836
Robert E. Cohen, PsyD, Clinical Director
Elizabeth Morgan, PhD **Maria M. Coiro, PhD**
Kenia Rodriguez-Spengler, PsyD **Karen Mikolic, PhD**

Recreation

Briefly list the types of recreation (sports, TV, games, hobbies, etc) that you enjoy:_____

_____

Substance Use History

Alcohol

I started drinking at age: Less than 10yrs old_____ 10-15_____ 16-18 _____ 19-21_____ over 21_____
I drink alcohol: Rarely or never_____ 1-2 days a week_____ 3 -5 days a week_____ Daily_____
I used to drink but have stopped:_____ Date stopped_____
Preferred type of drinks:_____
Usual number of alcoholic drinks I have at one time:_____
My last alcoholic drink was: Less than 24 hrs ago_____ 24-48 hours ago_____ Over 48 hrs ago_____
Check all that apply:

_____ I can drink more that most people my age and my size before I get drunk.
_____ I sometimes get in trouble (fights, legal or work problems, accidents, etc.) after drinking
_____ I sometimes blackout after drinking.

Tobacco

Do you smoke or chew tobacco? Yes_____ No_____ If yes, amount per day:_____

Drugs (Please check all the drugs you use now or have used in the past)

	Presently using	Dependent on	Used in past
Amphetamines (including diet pills)	_____	_____	_____
Barbiturates (downers)	_____	_____	_____
Cocaine or crack	_____	_____	_____
Hallucinogenics (LSD, acid, STP, etc)	_____	_____	_____
Inhalants	_____	_____	_____
Marijuana	_____	_____	_____
Opiate Narcotics (heroin, morphine, etc)	_____	_____	_____
PCP (or angel dust)	_____	_____	_____
Any other drugs?_____	_____	_____	_____

Do you consider yourself dependent on any prescription drug(s)? Yes_____ No_____
If yes, which one(s):_____

Check all that apply: _____I have gone through drug withdrawal
_____I have used IV drugs
_____I have been in drug treatment

DEPARTMENT OF NEUROPSYCHOLOGY
32 W. Gore St., 5th Floor, Orlando, FL 32806
Tel: 321.841.3820 *Fax:* 321.843.6836
Robert E. Cohen, PsyD, Clinical Director
Elizabeth Morgan, PhD **Maria M. Coiro, PhD**
Kenia Rodriguez-Spengler, PsyD **Karen Mikolic, PhD**

Medical Testing

Check all the medical tests that recently have been done and any abnormal findings:

	Check if normal	Abnormal Findings
___Angiography	_____	_____
___Blood Work	_____	_____
___CT scan	_____	_____
___MRI	_____	_____
___PET scan	_____	_____
___EEG	_____	_____
___Lumbar Puncture/spinal tap	_____	_____
___Neurological office exam	_____	_____
___Physicians office exam	_____	_____
___Ultrasound	_____	_____

Any other recent test results? _____

Identify the physician who is most familiar with your recent problems:

Name of physician:_____
Address:_____Phone_____
_____Fax_____
_____
Date of last check-up:_____
Findings of the check-up:_____

THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE!