Peter Gager, Ph.D.

NEUROPSYCHOLOGICAL HISTORY

DATE:
Examinee Name_____
Address (Street, City, ST, Zip)_____
Phone _____
Age_____ Birth date_____ Gender_____Education_____
Ethnic or Racial Background_____
Primary Language _____Secondary Language_____
Hand used for writing: (check one) Right hand_____ Left Hand_____
JobTitle_____

Medical diagnoses:
(1) _____
(2) _____
(3) _____
(4) _____
(5) _____
(6)_____

Who referred you for this evaluation?_____
Please rate problems/concerns in order of importance:
(1)_____
(2)_____
(3)_____
(4)_____

Describe any old or new difficulties:

1) PROBLEM SOLVING

2) SPEECH, LANGUAGE, AND MATH SKILLS

3) NONVERBAL SKILLS

4) CONCENTRATION AND AWARENESS

5) MEMORY

6) MOTOR AND COORDINATION

7) SENSORY

8) PHYSICAL
□ _____ Headaches Where:_____Intensity:_____Duration:_____
□ _____ Dizziness
□ _____ Nausea or vomiting
□ _____ Excessive tiredness
□ _____ Pain Location: _____
Duration:_____
Intensity (0-None, 10-Worst its been) 1 2 3 4 5 6 7 8 9 10
How does it affect your emotions and activities:_____

What helps the pain: _____

9) BEHAVIOR **Rate how severe:**

ü **Check all that apply to you in the past six months:** **Mild Moderate Severe**

_____ Sadness or depression _____ _____ _____
_____ Anxiety or nervousness _____ _____ _____
_____ Stress _____ _____ _____
_____ Sleeping problems: (Falling asleep__Staying asleep__) _____ _____ _____
_____ Become angry or irritable more easily _____ _____ _____
_____ Euphoria (feeling on top of the world) _____ _____ _____
_____ Much more emotional (e.g., cry more easily) _____ _____ _____
_____ Feel as if I just do not care anymore _____ _____ _____
_____ Feel like hurting myself and/or another person _____ _____ _____
_____ Less inhibited (do things I would not do before) _____ _____ _____
_____ Hear voices or see things others do not hear or see _____ _____ _____
_____ Change in eating habits:_____
Change in interest in sex:_____
Other recent change in behavior or personality:_____

10) Overall, my symptoms have developed: _____ Slowly _____ Quickly
11) My symptoms occur: _____ Occasionally _____ Often
12) Over the past 6 months my symptoms have: _____ Stayed about the same
_____ Worsened_____ Gotten better

EARLY HISTORY

13) You were born On time _____ Prematurely _____ Late _____
16) Were there any problems associated with your birth or your mother's pregnancy?
If yes, describe:_____

20) Rate your developmental progress as it has been reported to you by checking one description for each area:

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

21) As a child, did you have any of these conditions? (Check all that apply.)

_____ Attention problems _____ Head injury _____ Muscle tightness or weakness
_____ Clumsiness _____ Hearing problems _____ Speech problems
_____ Developmental delay _____ Hyperactivity _____ Vision problems
_____ Ear infections _____ Learning disability _____ Psychological problems
_____ Problems socializing _____ Drug use _____ Involvement with police or Authorities

Other problems:_____

MEDICAL HISTORY

CHILDHOOD MEDICAL HISTORY

22) Check all the conditions that were diagnosed when you were a child. Add any helpful details (age at diagnosis, treatment provided, etc.)

_____ Allergies _____ Epilepsy or seizures _____ Pneumonia
_____ Asthma _____ Fevers (104 F or higher) _____ Poisoning
_____ Brain infection _____ Heart problems _____ Polio
_____ Cancer _____ Immune system disease _____ Rheumatic fever
_____ Cerebral palsy _____ Kidney problems _____ Scarlet fever
_____ Chicken pox _____ Lung (respiratory) disease _____ Tuberculosis
_____ Colds (excessive) _____ Measles _____ Venereal disease
_____ Diabetes _____ Meningitis _____ Whooping cough
_____ Encephalitis _____ Oxygen deprivation _____ Psychological
_____ Other diseases or disabilities:_____

_____

23) As a child, were you exposed to excessive amounts of lead (e.g., eating paint chips, living next to high Concentration of automobile exhaust fumes, etc.)? _____ Yes _____ No
If yes, explain:_____
24) As a child, did you have an accident which required a hospital visit? _____ Yes _____ No
If yes, describe what happened:_____

25) Did you ever suffer a serious injury to your head? _____ Yes _____ No
If yes, explain the circumstances and any problems you had afterward:

_____

_____

27) List the medications that were regularly given to you as a child:

	Medication	Reason for medication
a)	_____	
b)	_____	
c)	_____	
d)	_____	

ADULT MEDICAL HISTORY

28) Check all that currently apply:

_____ AIDS or HIV+	_____ Heart disease	_____ Parkinson disease
_____ Allergies	_____ Huntington disease	_____ Polio
_____ Arteriosclerosis	_____ Hypertension	_____ Psychiatric problems
_____ Arthritis	_____ Kidney disease	_____ Radiation exposure/ Therapy
_____ Blood disorder	_____ Liver disease	_____ Senility (Dementia)
_____ Brain infection	_____ Lung disease	_____ Stoke or TIA
_____ Cancer or chemo	_____ Malnutrition	_____ Thyroid disease
_____ Diabetes	_____ Meningitis	_____ Venereal disease
_____ Hazardous exposure	_____ Multiple sclerosis	_____ Arrest or incarceration

_____ Any other problems:_____
_____

29) Have you ever been placed on disability? _____ Yes _____ No
If yes, please explain:_____

30) List any medication you currently take (over-the-counter or prescription medication) and the dosage.

	Medication	Dosage	Usage
a)			
b)			
c)			
d)			
e)			

31) Do you have epilepsy or a seizure disorder? _____ Yes _____ No

32) Describe all of the hospitalizations you have had:

a)
_____
b)
_____
c)
_____
d)
_____

FAMILY HISTORY
The following questions deal with your biological mother, father, brothers, and sisters.
MOTHER
34) Is she alive? Yes_____ No_____ If deceased, what was the cause of death?_____

38) Does your mother have a suspected learning disability or psychological disorder? Yes_____ No_____
If yes, describe:
_____
40) Briefly describe your mother's health history:_____

FATHER
41) What is your father's name?_____
42) Is he alive? Yes_____ No_____ If deceased, what was the cause of death?_____

46) Does your father have a suspected learning disability or psychological disorder?
Yes_____ No_____. If yes, describe: _____
48) Briefly describe your father's health history:_____
_____

50) How many brothers and sisters do you have? _____
52) Are there any problems (physical, academic or psychological) associated with any of your brothers or sisters? Yes_____ No_____
If yes, describe:_____
_____
_____
53) Who raised you?
_____ Biological parent(s) _____ Relatives Other Who?_____
54) What languages were spoken at home when you were a child?
1) _____
2) _____

55) Please check all that exist(ed) in close biological (blood) **family members** (parents, brothers, sisters, grandparents, aunts, uncles). Note who it was and describe the problem where indicated.
Who?
_____ Epilepsy or seizures _____
_____ Learning disability _____
_____ Left-handedness _____
_____ Mental retardation _____
Neurological (brain) disease
_____ Alzheimer's disease or senility _____
_____ Huntington disease _____
_____ Multiple sclerosis _____
_____ Parkinson disease _____
_____ Other neurological disease (describe) _____
Psychiatric illness
_____ Alcoholism _____
_____ Bipolar illness (manic-depression) _____
_____ Depression _____

_____ Personality disorder _____
_____ Schizophrenia _____
_____ Other psychiatric illness (describe) _____
_____ Speech or language disorder _____
_____ Other major disease or disorder (describe) _____

PERSONAL HISTORY

MARITAL HISTORY

56) Current marital status: Married_____ Divorced_____ Widowed_____ Separated_____
57) Years married to current spouse: _____
58) Number of times married: _____
64) Do you have any children: Yes_____ No_____ Ages:_____
65) Do your children have learning disabilities or other systemic diseases? Yes_____ No_____
If yes, please explain:_____
_____

EDUCATIONAL HISTORY

66) Highest grade or degree earned:_____
67) How would you describe your usual performance as a student in (please circle highest level):

	Name of School	# Yrs	Date Finished	Average Grade	Diploma
Grades 1-6					
7-8/9					
9/10-12					
University					
Post-graduate					
Other					

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

68) What was your best subject(s)? _____ Weakest subject(s)_____
69) Were you ever held back to repeat a grade? Yes_____ No_____
If yes, what grade(s):_____
Reason:_____
70) Were you ever in any special class(es) or received special services? Yes_____ No_____
If yes, what grade? _____ or age?_____ What type of class?_____
_____

OCCUPATIONAL HISTORY

71) Current job title:_____
73) How long have you been on this job? _____
74) Current job responsibilities:_____
_____
_____
_____
75) Prior jobs:

(Start with most recent)	Reason for leaving	Time on this job
a)		
b)		
c)		
d)		

76) At any time on a job, were you exposed to toxic, hazardous, noxious or otherwise dangerous or unusual substances (e.g., lead, mercury, radiation, solvents, pesticides, chemicals, etc)?
Yes_____ No_____

MILITARY HISTORY
77) Branch:_____Discharge rank: _____Type discharge:_____
79) Major military duties:_____
80) Did you sustain any physical injuries in the military
Combat exposure? Yes_____ No_____
If yes, describe:_____
81) Were you ever exposed to any dangerous or unusual substances during your service (e.g., Agent Orange, radiation, etc? Yes_____ No_____. If yes, explain:_____

RECREATION/SOCIALIZATION
82) Briefly list the types of recreation activities (sports, games, TV, hobbies, etc.) you engage(d) in?
_____

SUBSTANCE USE HISTORY ALCOHOL
86) I started drinking regularly at age:
Less than 10 years old _____ 10-15_____ 16-18_____ 19-21_____ over 21_____
87) I drink alcohol: rarely or never_____ 1-2 days/week_____ 3-5 days/week_____ Daily_____
I used to drink but have stopped_____ Date stopped_____
89) Usual number of drinks I have at a time:_____
90) My last drink was: Less than 24 hours ago_____ 24-48 hours ago_____ over 48 hours ago____
91) Check all that apply:
_____ I can drink more than most people my age and size before I get drunk.
_____ I sometimes get into trouble (fights, legal difficulty, problems at work, conflicts with family, accidents, etc.)
after drinking
_____ I sometimes black out after drinking
Date of last time you had 4 or more drinks on one occasion or day:

DRUGS
92) Please check all the drugs you are now using or have used in the past:

	Currently using.	**Used in the past**
_____ Amphetamines (inc. diet pills)	_____	_____
_____ Barbiturates (downers, etc.)	_____	_____
_____ Cocaine or crack	_____	_____
_____ Hallucinogenics (LSD, acid, STP, etc.)	_____	_____
_____ Inhalants (glue, nitrous oxide, ect.)	_____	_____
_____ Marijuana	_____	_____
_____ Opiate narcotics (heroin, morphine, etc.)	_____	_____
_____ PCP (or angel dust)	_____	_____

Please list all other drugs:
_____

(93) Do you consider yourself dependent on any above drug? Yes_____ No_____
Which one(s)?
_____

94) Do you consider yourself dependent on any prescription drug? Yes_____ No_____
Which one(s)?
_____

95) Check all that apply:
_____ I have gone through drug withdrawal
_____ I have used I.V. drugs _____ I have been in drug treatment
96) Have you ever been arrested for, or convicted of, any offense? Yes_____ No_____
If so, explain:_____

MEDICAL

98) Have you had a prior psychiatric, psychological or neuropsychological evaluation? Yes_____
No_____. If yes, complete this information:
Name of Doctor:_____
Date of and reason for this evaluation_____

Findings of the evaluation:_____

_____

99) Is there any other information that you believe would be relevant to this evaluation?
_____

_____

100) What do you believe is your biggest problem?
_____

101) Are you presently involved in a lawsuit? Yes_____ No_____
If so, what?_____

102) Do you presently operate a vehicle? Yes_____ No_____
Do you have a current license? Yes_____ No_____ State:_____. Restrictions?_____
Driving difficulties or tickets and dates?_____

Type of certificate/license (ATC, private, commercial, ATP):
_____Initial _____Renewal
Year first certified:
If student, hours of instruction:
Medical certificate class (I, II, III):
Prior special issuances: Reason:
Ratings:
Prior Cogscreen AE administrations and dates:

Name of person completing this form_____

Relationship to to Examinee_____

I verify that the information entered on this form is accurate

_____
Signature