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 often a genetic family history, as many problems are inherited (e.g., depression, learning problems, anxiety disorders).

Please complete this form and return to Neurobehavior North, Inc. prior to your appointment.

I. DEMOGRAPHIC & REFERRAL INFORMATION

Full Legal Name: _____ Sex: ☐ M ☐ F

Mailing Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____

Home Ph.: _____ Work Ph.: _____

Email Address: _____ Cell Ph.: _____

Referred By: _____ SSN: _____

What is your ethnic background?

☐ Asian/Pacific Islander ☐ Hispanic/Latino ☐ Native American/Alaskan
☐ African American ☐ Caucasian ☐ Other: _____

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

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II. 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

Changes in:

- ☐ Speech/Language
- ☐ Reading
- ☐ Sense of Smell
- ☐ Sense of Taste
- ☐ Frustration Tolerance
- ☐ Pain in chest
- ☐ Anxiety
- ☐ Decreased attention/concentration
- ☐ Fatigue easily
- ☐ Poor sleep
- ☐ Decreased energy
- ☐ Weight loss/gain
- ☐ Difficulty with crowds
- ☐ Mood swings
- ☐ Hallucinations
- ☐ Math Skills
- ☐ Anger
- ☐ Thinking
- ☐ Stress Tolerance

Do you currently need help with daily activities (e.g., dressing, cooking, driving)? ☐ Yes ☐ No

If yes, please specify: _____

_____

III. HEALTHCARE HISTORY

Primary Care Physician: _____Phone: _____

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
- ☐ Brain Tumor
- ☐ Sleep Apnea
- ☐ Thyroid disease
- ☐ Liver disease
- ☐ 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
- ☐ HIV/AIDS
- ☐ Oxygen Deprivation
- ☐ Hepatitis C
- ☐ Multiple Sclerosis

☐ Other _____

Please check any you have experienced or are experiencing now:

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

☐ Other _____

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 _____

How often do you have 6 or more drinks on one occasion?

☐ Daily ☐ 2-3 time per week ☐ 3-4 times per month ☐ rarely ☐ never

If no, have you ever drank? ☐ Yes ☐ No Date of last alcohol use? _____

Has your alcohol use ever caused problems? ☐ Yes ☐ No

Explain _____

Do you currently use, or have you ever used, any of these substances?
Circle either "Y" for "yes" or "N" for "no."

	Used in the past	**Current use**	**Estimated # of times**	**Estimated date of last use:**
Marijuana	Y / N	Y / N		
Amphetamines, "speed", meth, crank	Y / N	Y / N		
Cocaine	Y / N	Y / N		
Hallucinogens (LSD, mescaline, peyote, STP, psilocybin, "shrooms")	Y / N	Y / N		
Barbiturates (downers)	Y / N	Y / N		
Opiates, heroin, etc.	Y / N	Y / N		
Solvents, glue, aerosols, "huffing"	Y / N	Y / N		
Others (please name):	Y / N	Y / N		

Have you ever completed a substance abuse treatment program? ☐ Yes ☐ No

Have you ever used I.V. drugs? ☐ Yes ☐ No

Have you ever been addicted to prescription drugs? ☐ Yes ☐ No

Sleep:

How many hours do you sleep on a typical night? _____

How long does it take you to fall asleep after getting in bed? _____

How frequently do you awaken in the middle of the night? _____

Physical activity: Do you engage in regular physical activity? ☐ Yes ☐ No

If yes, please specify type and estimate frequency: _____

_____

Caffeine use: Do you consume beverages or supplements that contain caffeine, such as coffee, tea, soda, energy drinks, etc.? ☐ Yes ☐ No

If yes, please specify and estimate frequency and quantity: _____

Nutrition:

How many meals do you eat each day? _____

Have you noticed any recent changes in your appetite, diet, or weight? ☐ Yes ☐ No

If yes, please specify: _____

_____

Medications you currently take:

Medication	Dose (Mg)	How taken (e.g. 2 times daily, 3 times daily)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. DEVELOPMENTAL HISTORY

Place of Birth:_____ Birth weight: (if known) _____ Length: _____

Complications at birth? _____

Did your mother smoke, drink, or use drugs during pregnancy? ☐ Y ☐ N

As a child did you have any of the following?

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

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 _____

V. FAMILY INFORMATION

With whom do you currently live?

☐ Alone ☐ Friends ☐ Partner (not legally married)
☐ Spouse ☐ Group Home
☐ Family Members (relationship to you: _____)
☐ Other (who: _____)

Current relationship status (check all that apply):

☐ Married ☐ Never married ☐ Committed relationship
☐ Separated ☐ Divorced ☐ Widowed

Please list marriages and/or significant others, current and previous, with dates:

_____

_____

Moves in childhood: _____ #Moves in Adulthood: _____

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

NAME	AGE	SEX	GRADE	HOW IS SCHOOL GOING
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

OTHER PEOPLE IN THE HOUSEHOLD	AGE	SEX	EDUCATION	RELATION TO PATIENT
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

	NAME	AGE	OCCUPATION	EDUCATION	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
_____	___	_____	_____	☐Y ☐N

VI. 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 Addiction:	_____
Epilepsy:	_____
Mental Retardation:	_____
Dementia:	_____
Hyperactivity:	_____
Anxious or perfectionist:	_____
Speech or hearing problems:	_____
TIC behaviors or nervous habits:	_____
Psychiatric hospitalization:	_____
Other behavior or emotional problems:	_____
Parkinson's disease or MS	_____

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

_____

VII. EDUCATIONAL HISTORY

What is your highest educational degree completed?

☐ GED ☐ Some college, no degree ☐ Bachelor's Degree
☐ High School Graduate ☐ Associate's Degree ☐ Master's Degree
☐ Other: _____

List schools attended (public or private):

School	Grades	City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Estimated high school GPA: _____ Are school records available? ☐ Yes ☐ No

Education support required?

☐ Tutoring
☐ Remedial Classes
☐ Held back/repeated grade
☐ Underachiever
☐ Poor Motivation
☐ Other: _____

☐ Attention/Concentration Problems
☐ Behavior problems
☐ Learning Problems
☐ Started school late
☐ Resource/Spec. Ed

Please explain any of the above: _____

_____

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

Best and worst academic areas? _____

Trade School/Community College: _____ Years attended: _____

Estimated GPA: _____ Certification/Diploma? _____

University/College: _____ Major/Minor: _____

Years Attended: _____ Estimated GPA: _____ Certification/Diploma? _____

Graduate School: _____ Graduate area of study: _____

Years Attended: _____ Estimated GPA: _____ Degree/date: _____

VIII. PERSONAL HISTORY

Current Occupation: _____

Current Employer: _____ How Long? _____

Previous Employer: _____ Position: _____

Previous Employer: _____ Position: _____

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: _____

IX. MILITARY EXPERIENCE

Branch: _____ Specialty Areas: _____ Highest Rank: _____

Were you deployed to a combat zone? ☐ Yes ☐ No

If yes, please indicate where you were deployed and approximate dates:

Location: _____ From: _____ To: _____
Location: _____ From: _____ To: _____
Location: _____ From: _____ To: _____
Location: _____ From: _____ To: _____
Location: _____ From: _____ To: _____

Please add any additional information that you feel is important for this evaluation:

_____

_____

_____

_____

_____