The Clinic

CONSULTING ◆ PSYCHOTHERAPY ◆ MEDICATION MANAGEMENT ◆ TRAINING ◆ SPEAKING

NEUROPSYCHOLOGICAL EVALUATION: PRECLINICAL INTAKE FORM

NAME OF PATIENT: _____

BIRTHDATE: _____

SEX/GENDER: _____

Highest degree: Right-/Left-handed Occupation: Marital Status:

Native Language: Ethnicity: Country of origin:

Reason for visit: Known neurologic disease:

Year of diagnosis: Who referred you?

What question can we answer for you?

Do you have any problems with cognitive/thinking abilities? If so, please describe:

Years since onset of cognitive/thinking changes:
☐ <=1 ☐ 2-5 ☐ 6-10 ☐ > 10

Overall, my symptoms have developed: ☐ Slowly ☐ Quickly

My symptoms occur: ☐ Occasionally ☐ Often

Over the past 6 months, my symptoms have: ☐ Improved ☐ Stayed the same ☐ Worsened

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Cognitive changes (CIRCLE RELEVANT):

Attention: difficulty with reading comprehension, thinking more slowly, easily losing train of thought, trouble paying attention in conversation, forgetting why you walked into a room, losing track of time or the day/date, trouble keeping track of movie plots
Describe:_____
Month/year of onset:_____

Memory: forgetting day to day events or conversations, repeating questions, forgetting appointments, trouble learning new information, trouble remembering names, trouble recognizing faces, misplacing items, difficulty remembering historical facts about yourself (jobs, past homes, historical news items), forgetting familiar information
Describe:_____
Month/year of onset:_____

Language: difficulty comprehending speech or responding to directions, trouble finding words, trouble naming objects, using incorrect words/terms, slurring or stuttering speech, rambling speech, difficulty with reading, writing, spelling, math
Describe:_____
Month/year of onset:_____

Sensation/Perception: loss of sensation, numbness, pins/needles, pain, loss of smell or taste
Describe:_____
Month/year of onset:_____

Motor Functioning: weakness, loss of coordination, loss of fine motor dexterity, tremors, jerky movements, involuntary movements, cramping, messy handwriting, small handwriting, unsteadiness, difficulty swallowing
Describe:_____
Month/year of onset:_____

Visuospatial Function: difficulty navigating, inability to recognize familiar landmarks, getting lost, neglecting one side of your field of view or one side of your body, trouble reading maps,

difficulty judging heights/depth/distance, difficulty distinguishing left from right, difficulty dressing, poorer drawing, difficulty with musical abilities
Describe:_____
Month/year of onset:_____

Executive Function: difficulty with problem-solving, multi tasking, making decisions, judgment, insight, planning ahead, reasoning, staying organized, learning or figuring out how to do new things (e.g., new electronics or programs)
Describe:_____
Month/year of onset:_____

Personality Changes: beliefs that others find odd, seeing or hearing things that others do not experience, lack of motivation, irritability, risky behavior, decreased empathy, repetitive behaviors, less socially engaged, change in appetite or food preferences, change in interests
Describe:_____
Month/year of onset:_____

Have you ever been diagnosed with a psychiatric disorder, or treated for psychological symptoms, such as depression, anxiety, PTSD? ☐Yes ☐No If YES, please describe:

Year	Provider	Diagnosis/description of treatment

Are you facing any current significant stressors?

Pain (describe/rate severity 1-10):
Treatments:

Sleep or Energy Problems (including excessive fatigue):
Changes in Everyday Living:

CIRCLE DIFFICULTIES:
Bathing, Dressing, Making it to the Bathroom, Maintaining Hygiene, Walking

Phone, Shopping, Cooking, Housekeeping, Laundry, Finances, Appointments, Repairs

Medications:
Forgetting Doses, Taking Incorrect Medications/Doses

Driving:
Becoming Lost, Accidents, Close Calls, Limits set on Driving (for distance, weather, nighttime)

Finances:
Mistakes, Forgetting to Pay Bills, Paying Bills More than Once, Trouble Calculating Change

Describe any above problems: _____

Who provides assistance (if relevant):_____

Where do you live now?_____Duration? _____

Who else lives with you? _____

Family History:

Father's Age/Age at Death ____ Cause of Death_____Education/Occupation_____

Mother's Age /Age at Death____ Cause of Death_____Education/Occupation_____

Please list any family member diagnosed with a neurological disorder (e.g., dementia, epilepsy, multiple sclerosis):

_____

_____

_____

_____

Early Life History:

Where were you born/raised? Were you born on time?

Delivery Complication ☐ Low Birth Weight ☐ Jaundice ☐ Oxygen Deprivation ☐ Premature

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When your mom was pregnant with you, did any of the following occur:

☐ Substance use ☐ Illness ☐ Poor nutrition

Developmental Abnormalities: ☐ Normal ☐ Delay in Milestones (sitting, standing, toileting, walking) ☐ Childhood medical illnesses ☐ Social problems ☐ Clumsiness ☐ Speech problems ☐ Muscle weakness ☐ Frequent ear infections ☐ Hearing problems ☐ Vision problems
Describe:_____

Education: Highest Education Completed (HS diploma vs. GED, list degrees)_____

☐ Learning Disability ☐ Attention Problems/hyperactive ☐ Remedial Classes
☐ Discipline Problems ☐ Repeated Grades ☐ Poor Motivation ☐ Grades _____

College Major_____Name of University_____
Best/ Subjects_____Worst Subjects_____

Current Work Status: ☐ full-time ☐ part-time ☐ unemployed ☐ retired

Please list your previous jobs:

Job	Year(s)	Reason for Leaving

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Hobbies_____

Military (branch, ending rank, job/MOS, discharge status)_____

Legal Problems (juvenile problems, civil litigation, charges, misdemeanors/felonies, jail/prison)

_____

Do you receive (or are you pursuing) disability income?_____

Are you currently working with an attorney for a brain related injury or other problem?_____

Recent Medical Findings (if known, include dates):

Blood Work_____Brain Imaging_____

Prior Neuropsychological Evaluation_____Lumbar Puncture_____

Medical Illness, Accidents, Hospitalizations (circle all that apply):

Numbness/ tingling ☐	Motor problems ☐	Vision/ hearing loss ☐	Encephalitis/ meningitis ☐	Headaches ☐	Dizziness/ fainting ☐	Cancer ☐
Balance change ☐	Seizures/epilepsy ☐	Stroke ☐	Heart attack ☐	Smoking ☐	Diabetes ☐	Hypertension, cholesterol ☐
Oxygen deprivation ☐	Nausea/vomiting ☐	Incontinence ☐	Heart disease ☐	Sleep apnea ☐	Head injury with loss of consciousness (how many, time unconscious) ☐	

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Please list any other serious medical illnesses, accidents, or hospitalizations that you have experienced:

Year	Diagnosis or Description, Treatments
_____	_____
_____	_____
_____	_____
_____	_____

Toxic Chemical Exposure (lead, solvents, poison): ☐NO ☐ YES
When_____Where_____
What Chemical(s)_____ Did you ever fail to wear protective gear?____

Substance Use (Current Amount, Period of Heaviest Use)

☐ Alcohol _____ ☐ Marijuana _____
☐ Cocaine _____ ☐ Other _____

Have friends, family, a doctor, or anyone else ever said that you drink or use drugs too much?

Have alcohol or drugs ever caused problems for you? What kind of problems?

What other medical conditions or diagnoses do you suffer from?

Year	Diagnosis or Description, Treatment
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all medications you are currently taking, include both prescription and non-prescription drugs

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Name	Dosage	Reason for taking current medication?

Other problems or concerns?

What are you hoping will result from this evaluation?

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