Name:_____

Referral Source Name:_____ Date of Service: _____

Chief Complaint History of Issue: Onset, Landmark Events, Recent Medical—Neuro etc.

_____
_____
_____
_____
_____

Age: _____ DOB:_____ Married Single Divorced

Handedness: ☐ Right ☐ Left ☐ AMB

Vision: Myopia, Hyperopia Astigmatic

Cultural/Ethnic Background: Education (# of Years Completed ONLY):_____

Primary Language: _____ ESL: Age:_____ Primary: _____

On Time – Late_____ Accompanied/Unaccompanied _____ Grooming: WNL Disheveled Poor

GAIT/Ambulation/ Posture/Orthostatic/Toe Drop/Shuffle/Backwards Falls Onset/Dates/Sequela:

Language/Speech: WNL Rate, Dysphasia Dysprosody Neologisms Dysarthria Poor Articulation Pragmatics:

_____
_____

Thought Process: linear and goal directed circumlocution - circumstantiality - tangentiality

Thought Content: WNL Alogical, Delusional:_____

Hallucinations: ☐ Y ☐ N: _____

Gross Attention:/Concentration/Conversational
TrackingWNL:_____

Mood: Euthymic, Depressed, Irritable, Dysthymic, Euphoric, Despondent: _____

Affect: Congruent: WNL- _____

WNL/Good Historian Poor Historian

Where did you live growing up? (States lived in, years lived in each state): BORN-

1. Place-	Years	2. Place-	Years
3. Place-	Years	4. Place-	Years

Additional Places:

Brothers:_____ Sisters:_____
Sibling Relations:_____

Living Parents: Mother: ☐Y ☐N: Death by_____ Age:_____ Occ:_____

Name:_____

Father: ☐Y ☐N: Death by_____ Age:_____ Occ:_____

Did you have Pregnancy complications when you were born? ☐ Yes ☐ No

_____

_____

Premature:_____ Natural:_____ C-Section: _____ NICU: _____

Fevers: _____ Toxins: _____ Hospitalizations:

_____

_____

_____

Did you have a Language delay? ☐ Yes ☐ No Speech Therapy:

Motor Problems ☐ Yes ☐ No (If No, Describe):

_____

_____

Abuse Type: _____ Age: _____ Duration:_____

Abuse Type: _____ Age: _____ Duration:_____

What was your relationship with your family like growing up? Check all that Apply:
Lived w/_____
Raised by:

_____

_____

Children ☐ Yes ☐ No ☐ N/A (names, ages, mental health problems, strengths)

_____

_____

_____

Graduated HS Where?_____

Current Grade/School _____ Average grades received_____

Specific learning disabilities_____

Failed Classes: ☐ Yes ☐ No Academic Probation ☐ Yes ☐ No When Failed?_____
School Problems? List Here:

Employment History: (summarize jobs you've had, Year, Month, Outcome?)
Began Working: Age_____
1. Industry/Years _____
2. Industry/Years _____
3. Industry/Years _____
4. Industry/Years _____
5. Industry/Years _____
6. Industry/Years _____
7. Industry/Years_____
Work problems: (List Here):

Military History: ☐ Yes ☐ No LEGAL HISTORY: ☐ Yes ☐ No Age 1st Off: _____

Name:_____

Charges_____ Year_____ Outcome _____

Charges_____ Year_____ Outcome _____

Charges_____ Year_____ Outcome _____

Drivers License?: ☐Y ☐N MVA?:_____ Suspended/Times:_____

Where do you live now? With Whom? Relationship Quality:

_____

_____

Current Providers Names & Credentials:

Height: _____ Weight: _____ Ideal Weight_____ Recent Weight Change: _____

Medical History Get Date of Onset, Frequency/Severity:

Pain: ☐Y ☐N

Headaches: ☐Y ☐N

Cardiac Issues: ☐Y ☐N Gastroenterological issues: ☐Y ☐N

Changes in olfactory or gustatory acuity : ☐Y ☐N

Numbness/reduced sensation/neuropathy: ☐Y ☐N

Fibromyalgia: ☐Y ☐N Chronic Fatigue Syndrome: ☐Y ☐N Lymes: ☐Y ☐N

Seizure: ☐Y ☐N

Hearing Problems: ☐Y ☐N Do you need a hearing test : ☐Y ☐N Chronic Ear Infections: ☐ Y ☐ N

Vision Problems: ☐ Yes ☐ No Do you need glasses? ☐ Yes ☐ No Do you need an eye exam? ☐ Yes ☐ No

What is your Vision Prescription: Myopia, Hyperopia:

Sleep behavior: ☐ Trouble Falling Asleep ☐ No Sleep for Days ☐ Restless Sleep ☐ Too Much Sleep

Onset:_____ Duration:_____ Severity:_____

EATING Behavior: ☐ Anorexia ☐ Eating Disorder ☐Binge Eating/ Purging ☐ Other Eating Problems?

Onset:_____ Duration:_____ Severity:_____

Current sexual problems: ☐ Yes ☐ No History of sexual problems? ☐ Yes ☐ No

Onset:_____ Duration:_____ Severity:_____

Additional Medical Comments:

Name:_____

Any history of head trauma? ☐ Yes ☐ No ☐ N/A 1. Date/Age:_____ 2. Date/Age:_____

3. Date/Age:_____ Did you lose consciousness ☐ Yes ☐ No ☐ N/A For how long?_____

PTA? ☐Y ☐N

Did you have any brain imaging post injury? ☐ Yes ☐ No ☐ N/A Was it abnormal? ☐ Yes ☐ No ☐ N/A

Ordering Dr.'s Name:

Medications Current/Drug Interactions Side Effects:
Name/Reason_____ mg_____ f_____ S/E_____
Name/Reason_____ mg_____ f_____ S/E_____
Name/Reason_____ mg_____ f_____ S/E_____
Name/Reason_____ mg_____ f_____ S/E_____
Name/Reason_____ mg_____ f_____ S/E_____
Name/Reason_____ mg_____ f_____ S/E_____

Allergies:

Surgical History: Age:_____ Reason:_____ Complications: _____

Age:_____ Reason:_____ Complications: _____
MRI/SPECT/Xray/EEG/CT/EKG/EMG/ANGIO etc.:

Psych History:
Provider:_____Year:_____ Diagnosis:_____ Outcome:_____

Provider:_____Year:_____ Diagnosis:_____ Outcome:_____

Provider:_____Year:_____ Diagnosis:_____ Outcome:_____

Provider:_____Year:_____ Diagnosis:_____ Outcome:_____

Substance Use: Age_____ Substance: _____ Details:_____
Age_____ Substance: _____ Details:_____
Age_____ Substance: _____ Details:_____
Age_____ Substance: _____ Details:_____

Genetics Mothers Side:

Genetics Fathers Side:

CURRENT LIFE STRESSES: ☐ Academic ☐ Finances ☐ Relational ☐ Occupational ☐ Other: _____
_____

Social
Network:_____

Name:_____

Memory C B M (Remote, Recent, Episodic) Parental Interview Data:
Age onset:

Suicide, Violence, Abuse
Attempts_____ SMB_____

Adaptive Functions: Anxiety Self Care PTSD Money Panic Hygiene OCD Executive Dysfunction GAD Insight Childhood Planning Reading, Writing, Math, DV Retardation, BIFunction	ADHD Sep. Anx. Hallucinations Delusions Mood Sexual Disorders ASPD OCPD HIST/NARS /SCZT/ SCZ/Avoidant Conduct ODD Dissociation Cog Disorder Somatoform Dissociate	Adaptive Functions: Self Care Money Communication Hygiene Executive Dysfunction Insight Planning Perseveration daytime drowsiness and lethargy, daytime sleep of 2 or more hours, staring into space for long periods, and episodes of disorganized speech. Optic Neuritis Tremors

Medical Data Continued:

_____

_____
_____

_____
_____

_____
_____

_____
_____

_____
_____

_____

Diagnostic Considerations: Accommodations/Interventions/Referrals:

Name:_____

Heaton/Reg Trails A:_____

ss = T =

Heaton/Reg Trails B:_____

ss = T =

REC RAW:_____

SS =

EXP RAW:_____

SS =

TOPMF/BARONA:

SS =

Token Test Raw:

%ile_____

BNT RAW:_____

T/Z:

Finger Windows Raw:_____ ss =

GPB Heaton/Reg DOM: Drops:

ss = T =

FTT DOM: _____

_____ _____ _____ _____ _____

_____ _____ _____ _____

Mean: = _____

GPB Heaton/Reg Non: Drops:

ss = T =

Grip DOM: _____

_____ _____

Grip NON-Dom:

_____ _____ _____

Symbol Raw:_____

ss =

PSI SS =

DSF Raw: ss =

DSB Raw: ss =

DSS Raw: ss =

Coding Raw:_____

ss =

#: learned_____

30"_____ 90"_____

60"_____ 120"_____

FAB Raw: _____

CLOX 1: _____

CLOX 2: _____

FTT NON: _____

_____ _____ _____ _____ _____

_____ _____ _____ _____

Mean: = _____

RCFT: Copy

Imm: T =

Delay: T =

Piece - Gestalt

Org -Dis

CVLT: Slope____

Judgment Cog:

Raw:_____

LMI: ss =

LMII: ss =

Recog: ss =

DKEFS DESIGN

1: _____ ss =___e__

2: _____ ss =___e__

3: _____ ss =___e__

Heaton/DKEFS FAS RAW:

ss/T:

Heaton/DKEFS Category RAW:

ss/T:

Heaton/DKEFS Category Sw RAW:

ss/T:

JLO: Raw Score

T=_____

Math Fluency:

+ Raw_____

-Raw_____

X-Raw_____

Word Reading Raw:_____ 30_____

Psuedo: Raw:_____ 30_____

Spelling Raw: _____

RAIS Raw:

T= _____

Sentence Rep Raw_____

Num Ops Raw_____

ORF: Time_____Add_____Other

ORF: Time_____Add_____Other

Reading Comp Raw:_____

Name:_____

General Observations: