KREIG D. ROOF, PH.D.
PRACTICE OF NEUROPSYCHOLOGY

ADULT HISTORY FORM

Patient's Name: _____

Age:_____ **Date of Birth:**_____**Sex:**_____**Education:**_____

Primary Language:_____**Secondary Language:**_____

Hand used for writing: Right Hand: ☐ **Left Hand:** ☐

Current Job Title/years in position:_____

Current job responsibilities: _____

Who referred you for this neuropsychological evaluation?_____

Briefly Describe the Problem and when it first began:_____

_____

_____

What specific questions would you like answered by this neuropsychological evaluation? _____

_____

_____

_____

Medical Diagnosis (if any): _____

_____

_____

Please list all inpatient hospitalizations: include the name of the hospital, when, and reason

_____

_____

_____

List any medications you currently take and the dosage. Please include supplements and over the counter medications, as well. Continue on back of page, if needed.

_____

_____

_____

_____

_____

_____

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SYMPTOM SURVEY

For each symptom that applies, place a check mark on the line. Add any helpful comments next to the line.

	PROBLEM SOLVING	**Date of Onset**
	Difficulty figuring out how to do new things	
	Difficulty planning ahead	
	Difficulty figuring out problems that most other people can do	
	Difficulty thinking as quickly as I used to be able to think	
	Difficulty doing things in the right order (sequence problems)	
	Difficulty completing an activity in a reasonable amount of time	
	Difficulty doing more than one thing at a time	
	Difficulty switching from one activity to another activity	
	Other problem solving difficulties:	

	SPEECH, LANGUAGE, AND MATH SKILL	**Date of Onset**
	Difficulty finding the right word	
	Difficulty understanding what others are saying	
	Lose track of what I am saying in a conversation	
	Difficulty with following conversations	
	Difficulty writing letters or words (not due to handwriting)	
	Difficulty with math (e.g., checkbook balancing, making change, etc.)	
	Difficulty understanding what I read	
	Other speech, language, or math problems:	

	CONCENTRATION AND AWARENESS	**Date of Onset**
	Highly distractible	
	Lose my train of thought easily	
	Become easily confused and disoriented	
	I get lost or confused in familiar surroundings	
	I start tasks but have difficulty completing them	
	Other concentration or awareness problems:	

	MEMORY	**Date of Onset**
	Forgetting where I leave things (e.g., keys, gloves, etc.)	
	Forgetting names	
	Forgetting where I am or where I am going	
	Forgetting events that happened quite recently (e.g., my last meal)	
	My family tells me that I forget conversations or ask the same questions	
	My family tells me that I ask the same questions over and over	
	Frequently forgetting appointments	

MOTOR AND COORDINATION **Check the side this occurs on:**

		Right side	Left side	Both Sides	Date of Onset
	Fine motor control problems (e.g., using a pencil, key, etc.)				
	Weakness on one side of my body				
	Difficulty holding onto things				
	Tremor or shakiness				
	Problems with my balance				
	Often bumping into things				
	Other motor or coordination problems:				

SENSORY **Check the side this occurs on:**

		Right side	Left side	Both Sides	Date of Onset
	Loss of feeling or numbness				
	Tingling or strange skin sensations				
	Difficulty telling hot from cold				
	Problems seeing on one side				
	Blurred vision				
	Blank spots in vision				
	Brief periods of blindness				
	See "stars" or flashes of light				
	Double vision				
	Changes in my peripheral vision (seeing things to the side)				
	Hearing difficulties				
	Ringing in my ears or hearing strange sounds				
	Foods don't taste the same				
	Difficulty smelling				
	Smelling strange odors				

BEHAVIORAL/MOOD Check all that apply to you in the past 6 months

		Mild	Moderate	Severe	Date of Onset
	Sadness or depression				
	Anxiety or nervousness				
	Stress				
	Sleeping problems: (Falling Asleep ___ Staying Asleep ___)				
	Become more angry easily, more irritable				
	Much more emotional (e.g., cry more easily)				
	Feel as if I just don't care anymore				
	Difficulty being spontaneous				
	Change in eating habits:				
	Change in interest in sex:				
	Loss of energy				
	Lack of interest in things I used to enjoy				
	Withdrawn from family and/or friends				

CHILDHOOD MEDICAL HISTORY (Check all the conditions that were diagnosed when you were a child)

	Allergies		**Epilepsy or seizures**		**Pnuemonia**
	Scarlet fever		**Heart Problems**		**Fevers (104^0F or higher)**
	Brain infection or disease		**Immune system disease**		**Poisoning**
	Rheumatic fever		**Kidney problems**		**Polio**
	Cerebral palsy		**Lung (respiratory problems)**		**Cancer**
	Chicken pox		**Venereal disease**		**Asthma**
	Colds (excessive)		**Whooping Cough**		**Diabetes**
	Oxygen deprivation		**Tuberculosis**		**Measles**
	Meningitis		**Encephalitis**		
	Other disease or disabilities:				

ADULT MEDICAL HISTORY (Check all that apply)
Please also note if there are any family members who have/had these diagnosed

	AIDS, ARC, or HIV+		**Heart Disease**
	Allergies		**Huntington's Disease**
	Arteriosclerosis (artery disease)		**Hypertension**
	Arthritis		**Kidney Disease**
	Blood Disease		**Liver Disease**
	Brain Disease		**Loss of consciousness**
	Cancer or chemotherapy		**Lung (respiratory) Disease**
	Parkinson's Disease		**Malnutrition**
	Psychiatric problems		**Meningitis**
	Senility (dementia)		**Multiple Sclerosis**
	Venereal Disease		**Polio**
	Hazardous substance exposure		**Radiation exposure or therapy**
	Thyroid Disease		**Severe Snoring/Sleep Apnea**
	Any other medical history:		

Are you currently in psychotherapy or under psychiatric care? _____ Yes _____ No

Have you ever been in psychotherapy or under psychiatric care? _____ Yes _____ No
Have you ever been prescribed medications for a mental or nervous condition _____ Yes _____ No

Do you use tobacco products? _____ Yes _____ No How much each day? _____
Do you drink caffeine? _____ Yes _____ No How much each day? _____

FAMILY HISTORY

Current marital status: Married ___, Single ___, Divorced ___, Widowed ___, Separated ____
Years married to current spouse: _____ Number of times married? _____
How many children do you have? _____ grandchildren? _____