Northwest Neurology

Patient Name:_______________________________

Date of Birth: _______________________________

Date of Visit: _______________________________

Age: _______________________________

Referred By: _______________________________

Please complete this form before your visit to the neuropsychologist.

Form completed by:____

What is the reason for today's visit?

____

____

What are your goals/hopes for today's visit?

____

____

Have you had changes in your memory, thinking or behavior? Yes __ No __

If the patient's family or friends have noticed changes then they should fill out this section of the form.

When were the symptoms first noticed (*month/year*)?_________

What was the first symptom(s)?:____

Progression has been: Rapid (< 2 months) Gradual (6mos-years) Stepwise

COGNITIVE

	Never (does not occur)	**Rare** (less than monthly)	**Occasional** (every week)	**Frequent** (daily / almost daily)
Not knowing date / time				
Not knowing where they are				
Short term memory loss				
Trouble maintaining focus				
Difficulty controlling impulses				
Difficulty with organization / planning				

Patient Name:_________________________ Date of Birth: _________ MRN: _______________

Trouble making decisions				
Poor judgment (dangerous actions, excess spending, etc.)				
Difficulty with word finding				
Difficulty understanding conversations				
Trouble writing				
Difficulty with reading				
Getting lost				

BEHAVIOR

	Never (does not occur)	**Rare (less than monthly)**	**Occasional (every week)**	**Frequent (daily / almost daily)**
Delusions (false beliefs such as paranoia or infidelity of a spouse)				
Hallucinations (seeing, hearing, etc. things that aren't there)				
Agitation /Aggression (refusing to cooperate, yelling, hitting)				
Depression / Sadness				
Anxiety / Nervousness				
Apathy / Indifference (lack of interest in the world or others)				
Disinhibition (impulsive, socially unacceptable behavior)				
Irritability (moody, gets angry easily)				
Motor behavior (pacing, rummaging, fidgeting, etc.)				
Sleep issues (insomnia, confusing day/night, fighting during sleep)				
Appetite (decrease, increase, change in food preference)				

MEDICAL / SURGICAL

(use back of sheet if necessary)

Are you right handed, left handed, or ambidextrous? (Please circle)

Do you have a history of head and/or brain injury? Yes ____ No ____

Patient Name:__________________________ Date of Birth: __________ MRN: ________________

Have you ever had a stroke or TIA (transient ischemic attack)? Yes ____ No ____

Have you ever had a seizure? Yes ____ No ____

Have you ever had a CT or MRI scan of your brain? Yes ____ No ____

MEDICAL

Illness	Year it started

SURGICAL

Type of Surgery	Year

MEDICATIONS

Current Medications:

Drug Name	Dosage	Times per day	Length of use

Over-the-Counter (Vitamins, supplements, laxatives, pain relievers, allergy medicine, cough medicine, etc.)

Name	Dosage	Times per day	Length of use

Patient Name:_________________________ Date of Birth: __________ MRN: ________________

REVIEW OF SYMPTOMS

Have you experienced any of the following problems:

General:
Weight change
Fatigue / malaise
Fever / Chills

Pain:
Local: (where): ____________
Generalized

Skin:
Rash / itching
Hives
Change in hair or nails
Sweating too much / too little

Eyes:
Wear glasses / contacts
Double vision
Blurred vision
Visual loss
Dry eyes
Cataracts
Glaucoma

Ears:
Hearing loss
Ringing in ears
Dizziness (Vertigo)

Nose, Mouth and Throat:
Hoarseness
Dry mouth
Loss of sense of smell
Loss of sense of taste
Ear / Throat / Tooth Pain

Heart:
Fainting
Low blood pressure
High blood pressure
Chest pain
Slow / Fast heart rate
Irregular heart beat
Cold feet / hands
Leg swelling

Lungs:
Shortness of breath
Chronic cough

Gastrointestinal:
Change in appetite
Difficulty swallowing
Stomach pains / heartburn
Nausea/vomiting
Diarrhea
Constipation
Liver disease
Fecal incontinence

Metabolic:
Excess thirst
Heat / cold intolerance
Change in sexual interest:
increased / decreased
Hair loss
Change in voice
Thyroid problems
High cholesterol /lipids

Genital-urinary:
Difficulty urinating
Nighttime urination
Urinary urgency
Urinary incontinence / leakage
Urinary tract infection (recent)
Erectile dysfunction

Hematologic
Anemia
Swollen lymph nodes
Easy bleeding
Easy bruising

Musculoskeletal:
Muscle pain
Joint pain
Back pain
Fibromyalgia
Nighttime muscle cramps

Neurological:
Headaches
Muscle weakness
Numbness / tingling
Loss of balance
Falls
Slow movements
Tremor
Change in handwriting
Learning disability or ADHD
Insomnia
Tired in the morning
Falling asleep during day
Bedtime:________
Wake time: _________
Snoring
Stop breathing
Moving during sleep

Psychiatric:
Anxiety (nervousness)
Depression (sadness)
Previous psychiatric
hospitalization
Hallucinations
Delusions
Compulsive behavior
History of suicide attempt

Other: ____________________

____

DAILY FUNCTIONING

Do you drive? Yes _______ No _______ Never Drove __________

If yes, have you had any tickets or accidents in the last year? Yes ______ No ______

Have any concerns been expressed about your driving? Yes ______ No ______

If you are not driving, when did you stop? _______________ Why? _________________________________

(check one in each category / row)

TASK	Independent	Needs Some Assistance or Cueing	Needs Much Assistance	Unable to Do	Never did this task
Taking public transportation					
Shopping					
Housekeeping					
Meal preparation					
Handling finances (banking, investing, budgeting)					
Managing money (making change, paying bills)					
Taking Meds					
Using the telephone					
Doing laundry					
Socializing					
Getting dressed					
Bathing or showering					
Grooming (teeth, hair, shaving)					
Toilet hygiene					
Feeding self					

HEALTH HABITS

Do you currently or did you ever smoke? Yes ____ No ____

If yes, how many cigarettes per day? _______________ For how many years? ______________

If you quit smoking, when? _____________

Do you drink wine, beer or liquor? Yes _______ No ________

What and how often? ____

Has anyone ever been concerned about your drinking? Yes _______ No _______

Have you used other drugs / substances? Yes ______ No ________

What and how often? ____

Do you have any regular form of exercise? Yes ________ No ________

What and how often? ____

SOCIAL HISTORY

With whom do you live?____

(alone, spouse, child, other family, other-not family)

Do you get any help from family or friends in your home? Yes ______ No _______

If yes, please describe: ____

Are you using any agency or services for help at home? Yes _______ No _________

If yes, please describe: ____

Where do you live?

Own home

Senior apt.____________________________________

Condo

Assisted Living________________________________

Apartment

Nursing Home_________________________________

If you live at a care facility, please list contact person there.
Name:____ Phone:__________________________

Marital / Partnership Status:

Married How long?___________________________
Domestic partner How long?___________________________
Widowed How long?___________________________
Divorced/Separated How long?___________________________
Single/Never married
Other____

How many children do you have? ___________

Are you in regular contact with your children? Yes _______ No _______

How much education did you complete? (Please circle)

Less than 8th grade 8th grade Some high school High school

Some College College Graduate Graduate School Post-graduate

What kind of grades did you get in school? (Please circle)

Below Average Average Above Average

Did you ever use special education services? Yes ____ No ____

Did you ever repeat a grade? Yes ____ No ____

What is / was your Primary Occupation: ____

If retired, for how long? ________________

If still working, where? ______________________________ How many hours per week? _______________

Have you received any negative (performance related) feedback in the workplace? Yes ____No ____
Other significant past occupations: ____

FAMILY MEDICAL HISTORY

Continue on the back if necessary.

Include any serious medical problems and if anyone in the family had a history of Alzheimer's disease, other types of dementia, ALS or motor neuron disease, stroke, seizures or serious psychiatric illness.

Family Member	Living?	Age now or at death	Cause of death	List Medical/Neurological/Psychiatric Problems current or in the past (e.g. high blood pressure). Include age of onset if known.
Mother	Y N			
Father	Y N			
Brothers/Sisters (list):				
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
Children, Biological only (list):				
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			

Add information about grandparents, aunts/uncles, cousins if necessary: ________________________

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