PESI

Professional Exam Services, Inc.

2233 E. Grauwyler Road, Ste 107
Irving, TX
Phone: (972) 659-1235
Fax: (972) 223-2626
www.professionalexamservices.com

NEURO/PSYCHOLOGY HISTORY FORMS

Examinee Name: ________________________________ **Date:** ______________
(of appointment)

YOUR RESPONSIBILITIES FOR THESE FORMS:

- **ANSWER ALL QUESTIONS**
- **IF YOU HAVE A QUESTION, PLEASE ASK**
- **DON'T LEAVE QUESTIONS BLANK**
- **PUT YOUR INITIALS ON EACH PAGE**

You may use the back of any page to continue writing, if the space on the front is not enough.

I UNDERSTAND (SIGN BELOW)

____ ________________
Name ***Date***

IF YOU HAVE NOT BEEN REFERRED FOR A NEUROPSYCHOLOGICAL OR PSYCHOLOGICAL EVALUATION, THESE ARE THE WRONG FORMS!

THANK YOU!

Revised April 2022

Brief Injury History

YOUR NAME: ______________________________________ **DATE**: _______________________

Date you were hurt/injured: ________________________ **Your age then:** ____________

In your own words, how were you injured? *(You can use the back if necessary)*

____

____

____

____

____

Did you lose consciousness? YES NO *If yes, for approximately how long?* __________________

Were you dazed or disoriented? YES NO *If yes, for approximately how long?* __________________

What is your last memory before the injury/accident? ____

What is your first memory after the injury/accident? ____

What symptoms did you experience initially? ____

____

Overall, have the symptoms gotten better, worse, or stayed the same? ______________________________

Currently, what are your biggest concerns/complaints?______________________________________

____

____

Did anyone else witness the injury/accident? YES NO

If so, who?

____

Did an ambulance come? YES NO

Did you go to the emergency room? YES NO If so, where? _________________________________

Were you hospitalized? **YES** **NO**

If so, where, and for how long?____

Did you receive any head/brain imagining from the injury? **MRI** **CT** **Other** **None** **Don't know**

If so, when and what were the results? ____

____

Have you seen a <u>neurologist</u> since the injury? **YES** **NO**

If so, please specify name and treatment received: ____

Have you received any other treatment related to the injury (e.g. counseling, PT)? **YES** **NO**

If so, please specify type and frequency: ____

____

Have you been tested by a <u>psychologist</u> or <u>neuropsychologist</u> before this evaluation? **YES** **NO**

If so, who performed the testing and about when was it completed? ______________________________

____

Are you currently working? **YES** In the same job or a different job? ______________________

NO When did you last work? ______________________________

What is preventing you from working?

____

Are you applying for disability benefits as a result of this injury? **NO** **YES**

____

Do you have an attorney *for the injury you are here for today*? **NO** **YES**

NAME/LAW FIRM: ____

PHONE: ______________________________ FAX: ______________________________

Are you currently involved in any other legal cases? NO YES

If so, please specify: ____

Person completing this form: Self/Patient ___   Spouse ___   Parent ___   Other ________________

Date this form is being completed: __________________

GENERAL HISTORY

Patient's Name: ____

Date of Birth: _______________ Age: _____ Sex: ______ Race: _________ Marital Status: ____________

Address: ____ SS#: __________________

Phone #: ________________________ Email: ____

Injured while working? (Worker's Comp) No ___ Yes ___ Date of Injury ________________

Employer (when injured): ____________________________   Position/Job Title: ___________________

Injured in accident?   No ___ Yes ___ Cause __________________________ Date __________

Applying/Applied for Disability? No ___ Yes ___ Granted? ____ Denied? ____ Date ___________

Are you represented by attorney?   No ___ Yes ___ Attorney's Name ______________________

What doctor/who referred you here? ____________________

Who is your treating doctor (if different)? _____________________

Briefly explain the main concern / problem that brings you here today and why your doctor requested this evaluation. ____

____

____

____

Do you have specific <u>cognitive</u> problems (attention or memory problems, etc.)? No ___ Yes ___ (please explain)

____

____

When did these problems begin? ____

Did they begin: Abruptly ____   Gradually ____

Have they gotten: Better ____   Worse ____   Stayed the Same ____

Have you or others noticed changes in your:

Memory?   No ___ Yes ___ (explain) ____

Speech?   No ___ Yes ___ (explain) ____

Appearance?   No ___ Yes ___ (explain) ____

Mood or personality? No ___ Yes ___ (explain) ____

Movements or motor functioning?   No ___ Yes ___ (explain) _______________________________________

Developmental History:

Do you know if your mother had any difficulty during her pregnancy with you?

No _____ Unknown _____ Yes _____ (explain) ____

Were you born prematurely or were there any complications at the time of your birth?

No _____ Unknown _____ Yes _____ (explain) ____

Were there any problems with your development during childhood?

No _____ Unknown _____ Yes _____ (explain) ____

Parental Information:

Mother's highest level of education: _____________ Occupation: ______________________________

Medical/Psychiatric Problems: ____

Father's highest level of education: _____________ Occupation: _______________________________

Medical/Psychiatric Problems: ____

Have you ever had?

EEG	No ___ Yes ___ Date or Age ______ Results ___________________
CT scan	No ___ Yes ___ Date or Age ______ Results ___________________
MRI scan	No ___ Yes ___ Date or Age ______ Results ___________________
PET scan	No ___ Yes ___ Date or Age ______ Results ___________________
SPECT scan	No ___ Yes ___ Date or Age ______ Results ___________________
Spinal Tap	No ___ Yes ___ Date or Age ______ Results ___________________
Psychological Testing	No ___ Yes ___ Date or Age ______ By Whom_________________
Neuropsychological Testing	No ___ Yes ___ Date or Age ______ By Whom_________________
Brain Surgery	No ___ Yes ___ Age _____ Type/Location, if known:______________
Meningitis	No ___ Yes ___ Age _____
Encephalitis	No ___ Yes ___ Age _____
Cancer	No ___ Yes ___ Age _____ Type/Location, if known:______________
High blood pressure	No ___ Yes ___ Age _____
Low blood pressure	No ___ Yes ___ Age _____
Heart Disease	No ___ Yes ___ Age _____
Heart Attack	No ___ Yes ___ Age _____
Diabetes	No ___ Yes ___ Age _____ Type, if known:_____________________
Multiple Sclerosis	No ___ Yes ___ Age _____ Type, if known:_____________________
Parkinson’s Disease	No ___ Yes ___ Age _____

Have you ever had?

A fever of 104 or above? No ___ Yes ___ Age _____ (Explain: _____________________)
Loss of consciousness / Coma No ___ Yes ___ Age _____ (Explain: _____________________)
Head Injury No ___ Yes ___ Age _____ (Describe in section below)
Seizures No ___ Yes ___ Age _____ (Describe in section below)
CPR/artificial respiration? No ___ Yes ___ Age _____
Fibromyalgia No ___ Yes ___ Age _____
Chronic Fatigue No ___ Yes ___ Age _____
Lupus No ___ Yes ___ Age _____
Chronic Pain No ___ Yes ___ Age _____
Sleep Apnea No ___ Yes ___ Age _____
Lyme's Disease No ___ Yes ___ Age _____
Rocky Mountain Spotted Fever No ___ Yes ___ Age _____
Arthritis No ___ Yes ___ Age _____ (Explain: _____________________)
Emphysema No ___ Yes ___ Age _____
Anemia No ___ Yes ___ Age _____
Lead or Other Poisoning No ___ Yes ___ Age _____ (Explain: _____________________)
Migraine Headaches No ___ Yes ___ Age _____
Tension Headaches No ___ Yes ___ Age _____
Vision Problems No ___ Yes ___ Age _____
Do your glasses correct your visual difficulties? No ___ Yes ___ Not applicable ___
Cataract surgery No ___ Yes ___ Age _____ Both ___ Left ___ Right ___
Colorblind No ___ Yes ___ Type _________________ Age of Diagnosis _____
Hearing problems No ___ Yes ___ Age _____ Hearing aid? _________
Tremors/Shakiness No ___ Yes ___ Age _____
Dizziness No ___ Yes ___ Age _____
Frequent falling No ___ Yes ___ Age _____ (Explain: _____________________)
Sleep problems No ___ Yes ___ Age _____
Allergies No ___ Yes ___ Age _____
Asthma No ___ Yes ___ Age _____
Injured arms/hands/fingers No ___ Yes ___ Age _____
Other: ____

Current medication(s) and reason for taking: **Dosage (if known)**

______________________________ ____________
______________________________ ____________
______________________________ ____________
______________________________ ____________
______________________________ ____________

Medications used in the past for more than 3 continuous months: **Dosage (if known)**

______________________________ ____________
______________________________ ____________
______________________________ ____________
______________________________ ____________
______________________________ ____________

Please list any current medical illnesses (other than what you were referred): **Age of Onset/Diagnosis**

______________________________ ________
______________________________ ________
______________________________ ________
______________________________ ________
______________________________ ________

Please list/describe any past operations, surgeries, or hospitalizations: **Age at the time/Year**

______________________________ ________
______________________________ ________
______________________________ ________
______________________________ ________
______________________________ ________

If you ever had a head injury (i.e., concussion, brain injury, etc.), complete below:

Age at the time of your **current** head injury:________ Do you remember the actual event? No ___ Yes ___

Describe the head injury: ____

Did you lose consciousness? No ___ Yes ___ Length of unconsciousness: ________________________

What was your last clear memory before the injury? ____________________________________

What was your first clear memory after the injury? ____________________________________

Describe any medical treatment/medication you received in relation to the head injury: ______________________

____

List any physical symptoms you had following the head injury (i.e. vomiting, blurred vision, or headache):

____

How long did it take for you to get back to your "old self" after the head injury?

____

If you have had more than one head injury, please complete this section:

Age at the time of **other prior** head injury: _________ Do you remember the actual event? No ___ Yes ___

Describe the head injury: ____

Did you lose consciousness? No ___ Yes ___ Length of unconsciousness: ________________________

What was your last clear memory before the injury? ____________________________________

What was your first clear memory after the injury? ____________________________________

Describe any medical treatment/medication you received in relation to the head injury: ______________________

____

List any physical symptoms you had following the head injury (i.e. vomiting, blurred vision, or headache):

____

How long did it take for you to get back to your "old self" after the head injury? ____________________________

If you have had seizures, or have recurrent seizures, please complete this section:

Age of first seizure: _____ When was your last seizure: ____________________________________

Describe the seizure: ____

Did you lose consciousness during the seizure? No ___ Partially ___ Completely ___

How long does it take for you to recover or return to normal after having a seizure? ______________________

How often do the seizures occur (number per day, week, or month)? ______________________________

What mediations do you currently take for seizures? ____

____

(If you have had more than two head injuries, please describe them on the back of this page)

Mental Health

Have you ever experienced significant anxiety, depression, suicidal or homicidal feelings or attempts in the past or presently? No ___ Yes ___ (explain below)

____

Were your symptoms brought about by a specific cause(s) or specific incident(s)? No ___ Yes ___
(please explain if you feel comfortable doing so – otherwise please discuss with the neuropsychologist)

____

____

Have you ever had a mental health evaluation; treatment from a counselor, social worker, psychologist, psychiatrist, or church leader; or a related psychiatric hospitalization? No ___ Yes ___
Please describe any past or current psychological or psychiatric treatment below (including medications):

Type of Treatment	Age at that time	Reason
______________________	__________	______________________________
______________________	__________	______________________________
______________________	__________	______________________________

Has anyone in your family received mental health treatment or been hospitalized for mental health reasons?
No ___ Yes ___ (explain) ____

____

Did you experience any type of abuse before the age of 18? Yes ___ No ____
Check all types of abuse that occurred prior to age 18:
Physical ___ Emotional ___ Sexual ___
Have you experienced any type of abuse after the age of 18? Yes ___ No ____
Check all types of abuse that occurred after age 18:
Physical ___ Emotional ___ Sexual ___

Caffeine Use

Do you drink caffeinated beverages on a daily basis (e.g., coffee, tea, pop/soda)? No _____ Yes _____
If yes, specify the type and amount per day: ____

Tobacco Use

Do you currently use tobacco? No _____ Yes _____
If yes, specify the type and quantity per day: ____
How long have you used tobacco? ____
If you currently do not use tobacco, but have in the past, describe how much / how long you used tobacco:

____

Alcohol / Drug Use

Do you currently drink alcohol? No _____ Yes _____

If yes, specify the type and number of drinks per day or per week: ________________________________

For how long (since what age)? ____

If you currently do not drink alcohol, but did in the past, describe how much / how long you drank in the past:

____

Have you ever tried or taken recreational or street drugs? No ___ Yes ___ (circle all non-prescribed below)

Marijuana, Pot, Grass, Weed, Blunt, Dope, Joint, Hashish, Hash, THC, Reefer
Cocaine, Coke, Crack, Rock, Powder, Flake, Snow, Snorting, IV, Freebase, Speedball
Amphetamine, Speed, Crystal, Meth, Crank, Glass, Rush, Dexedrine, Ritalin, Adderall, Diet Pills
Codeine, Heroin, Morphine, Opium, Lortab, Methadone, OxyContin, Percodan, Dilaudid, Demerol, Vicodin
LSD, Acid, Mescaline, Ketamine, PCP, Angel Dust, STP, Mushrooms, Ecstasy, MDMA, MDA
Glue, Paint Thinner, Gasoline, Nitrous Oxide, Laughing Gas, Ethyl Chloride, Amyl or Butyl Nitrate/Poppers
Quaalude, Ludes, Barbs, Amytal, Seconal, Benzodiazepine, Valium, Xanax, Librium, Ativan, Dalmane
Halcion, Rohypnol, GHB, Downers, Sleeping Pills
Other recreational or street drugs: ____

First use / frequency / last use of circled drugs: ____
____

Have you ever received treatment to help you stop taking drugs or abusing alcohol? No ___ Yes ___

(explain) ____

____

Have you ever had any of the following because of your use of alcohol and/or drugs?

Relationship problems No ___ Yes ___ (explain) ____
Job problems No ___ Yes ___ (explain) ____
Legal problems No ___ Yes ___ (explain) ____

Social History

Have you ever served in the military? No ___ Yes ___

If yes, what branch of the military were you in? ______________________ Years served: ________

Highest Rank/position: ______________________________ Type of Discharge: ________________

Were you injured during you service? No___ Yes ___ (explain) ______________________________

Have you ever been arrested? No ___ Yes ___ (Charges?) _______________________________________

Have you ever done time in jail or prison? Never YES Where, How Long?

____

____

Do you have a valid driver's license? Yes ___ No ___ (explain) ____________________________________

Do you currently drive? Yes ___ No ___ (explain) ____

Did you drive yourself to the examination today? Yes ___ No ___ (Who did?) ____________________________

How many motor vehicle [car, truck, motorcycle] accidents have you been involved in the last 10 years?

none / 1 – 2 / 3 – 4 / 5 + How many were your fault? none / 1 – 2 / 3 – 4 / 5 +

What are your hobbies, interests, or favorite activities? ____

____

Hand you write with: _________ Left-handed family members?: ____________________________________

What is your current marital status? Married / Separated / Single, Never Married / Divorced

Widowed / Divorced & Remarried / Single, but living with a partner / other: ___________________

How many times have you been married? _________

Year of marriage #1: _________ to: _________ Now Married / Divorced / Death of spouse

Year of marriage #2: _________ to: _________ Now Married / Divorced / Death of spouse

Year of marriage #3: _________ to: _________ Now Married / Divorced / Death of spouse

Year of marriage #4: _________ to: _________ Now Married / Divorced / Death of spouse

Do You Have any children? ____NO ____YES Males, age(s): _________ Females, age(s): ________

Do any of your children live with you now? ____NO ____YES Which ones? ___________________________

Any Health Problems for your children? ____NO ____YES ____

____

Educational History:

Highest grade completed: _________________________ GED?: _________________________________

College or University Education: No _____ Yes _____ (if yes specify below)

Degree: ________ Major/Area: ___________________ Years: ______ Semester Hours: _______

Institution Name: _________________________ Location: ____

Technical or Vocational Training (if any): ____

Typical Grades on Report Card: ____

Skipped any grades? No _____ Yes _____ (explain) ____

Repeated any grades? No _____ Yes _____ (explain) ____

Special education classes, tutoring, or alternative school placement (if any): __________________________

Easiest subjects: __________________________ Difficult subjects: _________________________________

Employment History

Are you currently employed?

No ___ For how long? __________ Reason for unemployment: ______________________________

Yes ___ How long at your present job? ___________ What is your job title? ______________________

Describe your job: ____

Please list your most recent and/or most significantly relevant jobs (please use the back to continue):

DATES WORKED	JOB TITLE / COMPANY	JOB DUTIES	REASON FOR LEAVING

Sleep History:

Did you sleep the night before this evaluation? No _____ Yes _____ How Long?________________

Do you sleep well normally? No _____ Yes _____ My sleep problems began: ____________________

Which of these describe you best?

I often can't *get* to sleep / I often can't *stay* asleep / I often awaken *too early*, and can't get back to sleep

I often have bad dreams (or repeating dreams) about: ___________________________________

Do You Have *Sleep Apnea*? No / Yes Have to use CPAP Machine? No / Yes / Used to, but not now

In order to sleep, do you: take pills / drink alcohol / take a bath / meditate / none of these _______________

Have you ever thought seriously about, planned, or attempted suicide? _____ No _____ Yes

Reasons: ____

List Plans or Attempts:

Year _______ Method: Firearm / Jump / Overdose / Cut Wrist[s] / Crash Car / Other:_____________

Year _______ Method: Firearm / Jump / Overdose / Cut Wrist[s] / Crash Car / Other:_____________

Other: ____

Additional information that you believe is important for us to know when interpreting your test results:

____

____

____

____