THE CLINIC
NEUROPSYCHOLOGICAL & PSYCHOLOGICAL SERVICES

Patient History and General Intake Form

Patient's Name: _____

Date of Birth: _____ Age: _____

Gender: _____ Preferred Pronoun (e.g., he, she, they):_____

Address: _____ City:_____ St._____

Home Phone:_____ Cell Phone:_____

Email is not considered secure enough for private health information but may be used for scheduling. If you'd like to use email to schedule appointments, please provide the best email address for you here:

_____

Ethnicity:_____ Primary Language:_____

Handedness: R___ L___ Both___ Years of Schooling:_____

Who Knows you well and is involved in your care? (spouse, parent, other?)

Name: _____ Relationship:_____

Telephone number: (_____) _____

Referring physician:_____ Phone: (_____) _____

What would you like to learn from this evaluation? _____

_____

_____

_____

Has your physician/neurologist made any specific diagnoses: Yes___ No___

If yes, what were you diagnosed with? _____

_____

_____

_____

Briefly describe the problems/symptoms you are experiencing:

_____

_____

_____

_____

_____

_____

How long have these problems/symptoms been going on? _____

Have these symptoms progressed slowly or suddenly? (circle one)

Are your symptoms worse in the evening than the morning? Yes___ No___

Have your family members reported any other problems or symptoms you are not noticing? _____

_____

_____

_____

Please list all of your *current medical conditions*:

Please list all major surgeries you've had *in the past 10 years*:

Please list all the medical doctors you are *currently seeing*:

Name of Doctor	Specialty	Phone Number

Please list (or attach a list) of all of your *current medications*, including prescribed meds, vitamins, herbs, supplements:

Name of medication	Dosage	Frequency	Prescribing MD	What's it for?

Do you use medical or recreational marijuana? Yes ___ No ___

Have you had any of the following tests/scans

MRI (date) _____ MRI Results _____

CAT Scan (date) _____ CAT Scan Results _____

EEG (date) _____ EEG Results _____

Corotid Doppler Exam (date)_____ Results _____

Sleep Study (date) _____ Results _____

Neuropsychological Eval (date) _____ Results _____

Any other tests/scans? Lab Results _____

_____

_____

Please ask your physician/neurologist to fax us any MRI, CAT scans, lab results and/or clinical summaries of your condition to (737)-221-8934

Are you having any difficulties with any of the following:

	None	Mild	Moderate	Severe	Remarks
***Vision**					Glasses?
***Hearing**					Hearing Aids?
Smell/Taste					
Speech					
Coordination					
Movement					
Using your Arms					
Walking					Falls?
Incontinence					
Appetite					Wt Loss/Gain?
Sleep					Typical # hrs per night
Pain					
Do You Require Any Special Assistance?					Please explain.

*Please bring your glasses and wear your hearing aids to all appointments.

Are you *currently* experiencing difficulties with any of the following:

	None	Mild	Moderate	Severe	Remarks
Memory					Short-term? Long-term? How long?
Attention/Focus					Previous ADHD diagnosis?
Language					
Judgment					
Mood Disruptions					
Changes in Social Functioning					

Have you *recently* experienced any odd thoughts or problematic behaviors?

	None	Mild	Moderate	Severe	Remarks
Hallucinations					Auditory – Visual – Tactile – Other How long?
Delusions					
Misperceptions					
Personality Changes					
Other Psychosis					
Disorientation					

Are you *currently* experiencing any problems with important responsibilities or activities of daily living?

	None	Mild	Moderate	Severe	Remarks
Dressing					
Bathing/Hygiene					
Getting up and down					
Preparing meals					
Shopping for groceries					
Doing laundry					
Housekeeping					
Handyman work					
Writing a check or Paying bills					
Managing Finances					
Keeping track of appointments					
Driving/Navagating					
Using Electronic devices					Smart phone, remote control, computer

Have *you or your family noticed* any changes in the following abilities?

	Mild	Moderate	Severe	When Did this Begin?
Memory				Short-Term Long-Term
Word Finding				
Recalling Names of People				Family Members Long-time Friends
Verbal Comprehension				Due to Poor Hearing?
Recalling Names of Objects				
Driving				Recent Accidents
Getting Lost – either Driving or Walking				Familiar areas Unfamiliar areas
Changes in Mood or Emotional Reactions				
Changes in Personality				
Increased Anger or Irritability				
Increased Aggression or Violence				
Feeling Anxious or Nervous				
Feeling Depressed				
Decreased Social Interests				
Problems with Stamina or Fatigue				
Dinished Taste or Smell				Taste Smell
Changes in Appetite				Increased Decreased
Use of Your Hands Poorer Handwriting				
Math Abilities				
Reading Comprehension				
Attention or Concentration				

In this section, we will ask about your *medical history*.

Have *you ever been diagnosed* with any of the following?

	Yes – Approximate date/age of diagnosis	No	Unsure
Hypertension/High Blood Pressure			
High Cholesterol			
Anemia			
Thyroid Disease			
Diabetes			
Vitamin Deficiency			
Headaches/Migraines			
Seizure Disorder			
Traumatic Head Injury/Brain Tumor			
Dementia – including Alzheimer's Disease			
Parkinson's Disease			
Multiple Sclerosis			
Dizziness/Vertigo			
Fainting or Blackouts			
Stroke/Transient Ischemic Attack (TIA)			
Heart Attack/Congestive Heart Failure/Heart Disease			
Unexplained Loss of Consciousness			
Cancer			
Lung Disease			

In this section, we will ask about your *current and past* psychiatric/mental health care.

Are you now or have you ever been under the care of a psychologist or mental health counselor? Yes____ No ____

If you answered "Yes," please provide additional information below regarding your treatment.

Provider's Name/Clinic Name	Approximate dates of services	Diagnosis?

Are you now or have you ever been under the care of a psychiatrist or psychiatric nurse practitioner as an outpatient? Yes ____ No ____

If you answered "Yes," please provide additional information below regarding your treatment.

Psychiatrist's Name/Clinic Name	Approximate dates of services	Medication(s) Prescribed

Continued *current and past* psychiatric and mental health issues

Have you ever been hospitalized psychiatrically? Yes ____ No ____

Hosptial or Clinic Name	Approximate Dates	Length of Stay

Have you ever experienced any of the following mental health symptoms (whether they were diagnosed or undiagnosed)?

Symptoms	Yes – Approximate age of onset	No	Unsure
Depression	Recurrent -		
Anxiety			
Panic Attack			
Obsessive Thoughts – thoughts that intrude and won't go away			
Compulsions – actions that you feel you have to repeat over and over			
Posttraumatic Stress – not associated with the military			
Mood Swings			
Mania – feelings of feeling abnormally good or irritable, with excessive energy			
Suicidal Thoughts	Current – Past -		
Suicide Attempts	How many times – What Method -		
Homicidal Thoughts – thoughts of hurting others	Current – Past -		
Self-Harm – cutting, burning, etc.	Current – Past -		
Eating Disorder – Binging/Purging or Significant food restrictions			

In this section, we will ask about your *current and past use* of *alcohol*.

How often do you drink alcohol, beer or wine:

Daily _____ Weekly _____ Monthly _____ Occasionally _____

How many drinks do you have when you drink? _____

Have you ever felt you should cut down on your drinking? Yes ____ No ____

Has anyone in your family suggested you cut down on drinking?

Yes ____ No ____

Have people *annoyed you* by criticizing your drinking? Yes ____ No ____

Have you ever felt *bad or guilty* about your drinking? Yes ____ No ____

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? Yes ____ No ____

Have you ever been in treatment (inpatient, outpatient) for alcohol use?

Yes ____ No ____

If you answered "Yes," please complete the following:

Clinic Name/Provider's Name	Approximate date of services	Length of Stay

In this section, we will ask about your *current and past use* of *tobacco.*

Do you *currently* use any tobacco products (including vaping)?

Yes ____ No ____

If "Yes," what do you use?

Type of Tobacco	Amount/Frequency	Since what age?

Do you use any nicotine gum currently? Yes ____ No ____

Do you use a nicotine patch currently? Yes ____ No ____

Do you use any medications for smoking/tobacco cessation?

Yes ____ No ____

Have you used tobacco products *in the past*? If "Yes," what did you use?

Type of Tobacco	Amount/Frequency	When did you stop?

In this section, we will ask about your *current and past use of non-prescribed/illicit drugs*

Are you *currently using* any type of non-prescribed or illicit/street drugs, including marijuana? Yes ____ No ____

If you answered "Yes," please complete the following:

Name of Drug/Substance	Amount/Frequency	Age you began using	Method of administration

Have you *ever* used any type of non-prescribed or illicit/street drug?

If you answered "Yes," please complete the following:

Name of Drug/Substance	Amount/Frequency	Age you began using	Age you quit using/ Treatment?

In this section, we will ask about your Social/Family history.

Do you live alone? Yes _____ No _____. If "No," please complete below.

Name of Person(s) Who Live(s) with You	Their Current Age	Relationship

What is your current relationship status? Married _____ (how long?)
Partnered _____(how long?) Significant Other _____ (how long?)
Separated _____ (how long?) Divorced _____(how long?)

Other relationship status _____ (how long?)

How many times have you been married? _____ Divorced? _____

Do you have children (biological)? Yes _____ No _____

If you answered "Yes," please complete below

Name(s) of Your Children	Their Current Age	Relationship Son/Daughter

Social/Family History Continued

Birthplace: _____

Places you grew up: _____

Who did you grow up with? Mother _____ Father _____ Stepmother _____ Stepfather _____ Maternal Grandparent(s) _____ Paternal Grandparents ____

Other (specify): _____

Are either of your parents deceased? If so, please complete below.

Name of parent	Age at time of Death	Cause of Death

How many biological siblings do you have (by your mother and father together)? Number of brothers _____ Number of sisters _____

Where are you in the birth order? _____

Do you have any step/half siblings? Step/half Brothers _____ Sisters_____

Do you have any adopted siblings? Brothers _____ Sisters _____

Are any of your siblings deceased? If so, please complete below.

Name of Sibling	Age at time of Death	Cause of Death

Were there medical complications at the time of your birth? Yes ___ No ___

If you answered "Yes," please explain: _____

_____

_____

Were you born on time? _____ Premature? ____ How many weeks early ____

Birth weight? _____

Any complications at birth? _____

_____

Are you aware of any developmental delays in your childhood (e.g., talking, walking, motor delays, toileting, etc.? Yes _____ No _____

If you answered "Yes," please provide details here: _____

_____

_____

_____

_____

Please describe your childhood medical history, including any major illnesses, surgeries, hospitalizations, head injuries, seizure activity, loss of consciousness, sports injuries, etc. _____

_____

_____

_____

Were you exposed to toxic substances in childhood? Yes____ No ____

_____

_____

In this section, we will ask about your *family medical history*.

Has *anyone in your family been diagnosed* with any of the following:

	Yes – Which family member(s)	No	Unsure
Hypertension/High Blood Pressure			
Seizures/Epilepsy			
Dementia – such as Alzheimer's			
Strokes/Transient Ischemic Attacks			
Diabetes			
Heart Disease			
Cancer			
Neurological Disorder – such as Parkinson's			
Attention Deficit Disorder			
Developmental Disorder or Learning Disorders – Dyslexia, Dysgraphia, math learning disorder			
Alcoholism/Drug Addiction			
Psychiatric Disorder – Depression, Anxiety, Mood Disorder, Schizophrenia, etc.			
Personality Disorder			

In this section, we will ask about your *Educational history*

At what age did you begin school? _____ Where? _____

Did you graduate High School? Yes ____ No ____ GED? Yes ____ No ____

What year did you graduate High School or obtain your GED? _____

In what city/state did you graduate High School? _____

Did you experience any learning problems in school? Yes ____ No ____

If you answered "Yes," please explain:_____

_____

_____

_____

Did you receive any special education or other pull-out services in school? Yes ____ No ____ If you answered "Yes," please explain: _____

_____

_____

_____

Did you repeat any grades? Yes ____ No ____

Did you skip any grades? Yes ____ No ____

Did you attend school after High School? Yes ____ No ____. If you answered "Yes," please provide the following information:

Name of Institution/School/University	Dates Attended	Type of Degree

In this section, we will ask about your *Employment history*

Are you currently employed? Yes ____ No ____ Retired? Yes ____ No ____

Disabled? Yes ____ No ____ Are you on SSI/SSDI? Yes ____ No ____

What kind of work do/did you do in the past? _____

_____

If you are retired, when did you retire? _____

Was your retirement planned? Yes ____ No ____

Were you having any problems with your job performance before you retired? Yes ____ No ____ If you answered "Yes," please explain below:

_____

_____

_____

Please provide a chronology of your past work experiences during the past 10 years.

Company Name	Title/Position	How Long Were You There?	Why Did You Leave

During your employment, were you ever exposed to toxic chemicals, pesticides or lead paint? Yes _____ No _____

If you are currently Disabled, please specify your disability. _____

_____

In this section, we will ask about your *Military history*

Have you ever served in the Military? Yes ____ No ____

If you answered "Yes," please provide the following information:

Branch of Military	Highest Rank	Years Served	Discharge Status (Honorable, Dishonorable, etc.)

During your time in the military, were you ever exposed to burn pits, toxic chemicals, Agent Orange or other toxic substances? Yes ____ No ____

During your time in the military, or since your discharge, were you ever diagnosed with Posttraumatic Stress Disorder (PTSD)? Yes ____ No ____

Are you currently experiencing any symptoms of PTSD? Yes ____ No ____

If you answered "Yes," please check any symptoms you have been experiencing.

Symptom	Mild	Mod.	Severe	Symptom	Mild	Mod.	Severe
Nightmares				**Distressing Memories**			
Flashbacks				**Hypervigilance**			
Intrusive Thoughts				**Exaggerated Startle Response**			
Dissociation				**Feelings of Detachment**			
Self-Destructive Behaviors				**Negative Emotional States**			
Sleep Disturbances				**Distorted Cognitions**			

In this section, we will ask about your *Social Functioning*

Describe your temperament/personality (e.g., how do you handle frustrations? _____

_____

_____

_____

How do you spend your days usually? _____

_____

_____

_____

How do you spend your free time? _____

_____

_____

_____

What do you enjoy doing? What are your hobbies? _____

_____

_____

_____

Are you involved in any church or social groups or clubs? Yes ____ No ____

Describe your involvement. _____

_____

_____

_____

What is your greatest stressor currently? _____

_____

In this section, we will ask about any *Legal Issues*

As an adult, have you ever been arrested? Yes ____ No ____

If "Yes," please provide the following information/details.

Charge	Sentence	Time Served	Disposition Dropped/Convicted/Not Guilty

Are you currently on Probation/Parole? Yes ____ No ____

Name of Probation/Parole Officer _____

Telephone _____ Fax _____

Are you currently being sued or involved in a lawsuit? Yes ____ No ____

If "Yes," please provide a detailed explanation:

_____

_____

_____

_____

_____

_____

Who is your attorney?:

Name: _____

Address: _____

Telephone: _____ Fax: _____

In this section, we will ask about your *Insurance Information*

Primary Insurance _____ Policy # _____

Name on Insurance Policy _____

Secondary Insurance _____ Policy # _____

Name on Insurance Policy _____

Other Insurance _____ Policy # _____

Name on Insurance Policy _____

I understand that I am responsible for ensuring that my insurance is active at the time of the evaluation/assessment with The Clinic, and that even if my insurance pre-authorizes the evaluation/assessment, it may not be covered. In such cases, payment for the evaluation/assessment is my full responsibility.

Patient Signature: _____ Date: _____