

NEUROBEHAVIORAL LABORATORY INFORMATION FORM

NAME: _____ **AGE:** _____ **DATE OF BIRTH:** _____

1. Describe the problems you have been experiencing which led you to seek treatment and which resulted in your being referred for evaluation.

2. Do you consider yourself to be (Circle one):

Right handed Left handed Mixed handed

3. Have you always been this way or were you ever forced to change your hand preference? (Circle one):

Always the same Changed
 (If changed, indicate why and when):

4. Which hand do you prefer for the following activities? (Check one for each activity)

	Always Right	Usually Right	Either hand	Usually Left	Always Left
Writing	_____	_____	_____	_____	_____
Drawing	_____	_____	_____	_____	_____
Throwing	_____	_____	_____	_____	_____
Scissors	_____	_____	_____	_____	_____
Toothbrush	_____	_____	_____	_____	_____
Knife	_____	_____	_____	_____	_____
Spoon	_____	_____	_____	_____	_____
Twisting the lid off a jar	_____	_____	_____	_____	_____

5. Where were you born and raised? _____

If born outside of the United States, when did you move to the U.S.?? _____

6. Primary language spoken in the home: _____

Other languages spoken: _____

7. Race/ Ethnicity (Circle one): Caucasian/White Hispanic/Latino(a) American-Indian
 Black/African-American Asian/Asian-American Bi/Multiracial Other: _____

8. Sex Assigned at Birth (check one):

Female	Male
Intersex, assigned female	Intersex, assigned male

9: Pronouns (check one):

<input type="checkbox"/>	She/her	<input type="checkbox"/>	He/him/his
<input type="checkbox"/>	They/them/theirs	<input type="checkbox"/>	

10. Honorific you would like us to use (check one):

<input type="checkbox"/>	Miss	<input type="checkbox"/>	Mr.
<input type="checkbox"/>	Mrs.	<input type="checkbox"/>	Mx.
<input type="checkbox"/>	Ms.	<input type="checkbox"/>	Dr.
<input type="checkbox"/>	Only use my name (no honorifics)	<input type="checkbox"/>	

11. What is the highest level of education which you have completed? (Circle one)

Fewer than 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20+

Type of Degree(s) earned (i.e., High School Diploma, GED, A.A. B.A., M.A., Ph.D., etc.)? _____

12. How well did you do in elementary and middle school (Grades 1-8)? (Circle one)

Superior Above Average Average Below Average Failing

What were your best subjects? _____

What were your worst subjects? _____

13. How well did you do in high school (Grades 9-12)? (Circle one)

Superior Above Average Average Below Average Failing

What were your best subjects? _____

What were your worst subjects? _____

14. How well did you do in college (If you did not attend college, please skip)? (Circle one)

Superior Above Average Average Below Average Failing

What were your best subjects? _____

What were your worst subjects? _____

15. Did you ever receive any form of special instructions during elementary school and/or high school? (For example: tutoring, remedial classes, or special education classes).

YES NO

(If YES, please describe): _____

16. Did you ever have to repeat a grade either in grade school or high school? YES NO

If YES, please describe: _____

17. Did you experience behavior problems in school resulting in your being sent to the principal's office, or suspended, or expelled?

YES **NO**

If YES, please describe: _____

18. Please describe below any factors which may have prevented you from receiving a normal level of grade school and high school education. These factors might include things such as your family moving around frequently so that you had to attend many different schools, extended and/or frequent absences from school due to physical illnesses, or behavioral problems that interfered with your participation in classes. (Please be specific).

19. During childhood/adolescence have you ever suffered from: (Use your own judgment, regardless whether or not these were ever diagnosed)

Significant Reading Problems	YES	NO	DON'T KNOW
Math Problems	YES	NO	DON'T KNOW
Stuttering	YES	NO	DON'T KNOW
Withdrawing from other children	YES	NO	DON'T KNOW
Late acquiring speech (after age 3)	YES	NO	DON'T KNOW
Learning problems	YES	NO	DON'T KNOW
Childhood Attention problems	YES	NO	DON'T KNOW

If you circled "YES" to any of the above, please explain: _____

20. Please indicate the highest level of education completed *and* occupation of your:

Mother: _____ Father: _____

21. Are you aware of any complications your mother suffered during her pregnancy with you?

YES **NO** **DON'T KNOW**

If YES, what type of complications: _____

22. Are you currently on medication? YES NO

If Yes, indicate the medications, dose, and the frequency with which you take them: _____

23. Have you recently (within the past year) discontinued medication? YES NO

If YES, indicate the medications, dose, and the frequency with which you take them: _____

24. Please indicate if you ever had or presently have any of the following conditions.

Conditions	Yes	No	Year Diagnosed	Comment (if any)
High or Low Blood Pressure				
High Cholesterol				
Stroke				
Seizure				
Brain Tumor				
COVID-19 Infection(s)				
Sleep Apnea				
Heart Attack				
Atrial Fibrillation				
Coronary Heart Disease				
Sleep Apnea				
Diabetes				
Kidney Disorder/Problems				
Thyroid Disorder/Problems				
Unintentional Weight Loss				
Vision Problems/Changes				
Hearing Problems/Changes				
Lyme Disease				
Parkinson's Disease				
Multiple Sclerosis				
Cancer				
Mold or Toxin Exposure				
Numbness/Tingling				
Urinary Incontinence				
Balance Issues				

25. Are you currently experiencing any chronic pain? Yes NO Where: _____.

If yes, identify your current level of pain below on the scale:

0 (No Pain) - 2 (slight) - 4 (mild) - 6 (moderate) - 8 (severe) - 10 (worst pain)

26. Do you presently have a diagnosed medical illness or had a medical illness that is not in the above chart?

If YES, please list and briefly explain: _____

27. Have you ever been hospitalized or required surgery? YES NO

If YES, please explain: _____

28. Have you **recently** (in last 9 months) had a head injury? **YES** **NO** **DON'T KNOW**

If YES: Date of injury? _____

Location on head? _____

Did you lose consciousness? **YES** **NO** **DON'T KNOW**

For how long _____ hours _____ days _____ minutes

Were you hospitalized? **YES** **NO** **DON'T KNOW**

For how long _____ hours _____ days _____ minutes

Were you different or did you have any problems after your injury? **YES** **NO** **DON'T KNOW**

If YES, how were you different? _____

29. Have you ever **previously** had an injury to the head, neck, or spine? **YES** **NO**

If YES: How many? _____

What year(s)? _____

Location on head? _____

Did you lose consciousness? **YES** **NO** **DON'T KNOW**

For how long _____ hours _____ days _____ minutes

Were you hospitalized? **YES** **NO** **DON'T KNOW**

For how long _____ hours _____ days _____ minutes

Were you different or did you have any problems after your injury? **YES** **NO** **DON'T KNOW**

If YES, how were you different? _____

30. Has any member of your family been diagnosed with a neurological illness (check all that apply)?

Stroke:	Parkinson's Disease:
Alzheimer's Disease:	Other Dementia:
Multiple Sclerosis:	Huntington's Disease:
ALS:	Other:

31. Do you currently smoke cigarettes? **YES** **NO**

32. Did you smoke cigarettes regularly in the past? **YES** **NO**

If you answered YES, how many packs per day and for how long? _____

33. Has anyone in your family ever had a drinking problem? **YES** **NO** **DON'T KNOW**

*If YES, circle below the relative or relatives who had this problem:

Mother Father Sister Brother Other Relative

34. Do you currently ever use alcohol? YES NO

Did you ever drink alcohol excessively in the past? YES NO

How much and how frequently did you drink? _____

If you answered YES, please answer the following 4 questions:

Have you ever felt you ought to cut down on your drinking? YES NO

Have people annoyed you by criticizing your drinking? YES NO

Have you ever felt guilty about your drinking? YES NO

Have you ever had a drink first thing in the morning to steady your nerves and get rid of a hangover? YES NO

35. On average, how much do you drink in a week? (If you don't average at least one drink a week, how much would you drink in a month?): _____

36. During the time in your life when you drank the most, how much/how frequently did you drink?

37. Do you now or did you ever use "street" drugs, illegal drugs, or prescribed narcotic medications?

Currently Use: Yes No Use In The Past: Yes No

If you answered YES, please answer the following 4 questions:

Have you ever felt you depended too much on taking drugs as a way of coping with stress? YES NO

Has drug use ever interfered with your ability to do your job? YES NO

Has drug use interfered with your home or family life? YES NO

Have you ever felt that you shouldn't use drugs but found it hard to stop? YES NO

38. If you use or used drugs, which drugs and how often? _____

39. Has anyone in your family ever had a drug abuse problem? YES NO DON'T KNOW

*If YES, circle below the relative or relatives who had this problem:

Mother Father Sister Brother Other Relative

40. Have you ever seen a psychiatrist, psychologist, counselor, or other psychotherapist for assistance with personal or emotional problems?

YES NO

If YES, please provide a brief explanation: _____

41. How would you describe your current mood? _____

42. Has anyone in your family ever had psychiatric (mental or emotional) or cognitive (memory loss) problems?

YES NO DON'T KNOW

If YES, check below the relative or relatives who had these difficulties

	Psychiatric:	Memory Loss:
Mother	_____	_____
Father	_____	_____
Sister	_____	_____
Brother	_____	_____
Other Relative	_____	_____

43. Have you ever been hospitalized for personal or emotional problems? YES NO

If YES, please list hospitalizations: _____

44. Has anyone in your family been hospitalized for mental illness? YES NO DON'T KNOW

*If YES, circle below the relative or relatives who had this problem:

Mother Father Sister Brother Other Relative

45. Which best describes the illness or illnesses for which your relative(s) required treatment?

___ Depression	___ Alcohol or Drug Problems
___ Anxiety	___ Sexual Problems
___ Schizophrenia	___ Manic Behavior
___ Other problems: _____	

46. Have you ever attempted suicide? YES NO

Has anyone in your family committed or attempted suicide? YES NO DON'T KNOW

*If YES, circle below the relative or relatives who had this problem:

Mother Father Sister Brother Other Relative: _____

47. Have you had any problems with the law or, while in the military, had been subject to disciplinary action?

YES NO

If YES, describe: _____

48. Please indicate your marital status:

Married: ___ Domestic Partner: ___ Single: ___ Divorced: ___ Widowed: ___ Separated: ___

With whom do you live: _____

49. Do you have children? YES NO

If YES, please give their sex and ages: _____

50. Please list your most recent jobs (starting with the most recent and working backwards)

1. Job Title: _____ Years at this job: 20__ - 20__

Describe what you did: _____

2. Job Title: _____ Years at this job: 19__ - 20__

Describe what you did: _____

3. Job Title: _____ Years at this job: 19__ - 20__

Describe what you did at this job: _____

51. Have there been any problems at jobs that you believe are related to cognitive problems (e.g., memory, attention)?

YES NO

If YES, please describe _____

52. Are you presently involved in any legal actions relating to your current complaints (i.e. law suits related to personal injury or malpractice?)

Yes No

53. Did you serve in the military? Yes No

If yes, what branch? _____

Date(s) of service: _____

Certifications/Duties: _____

- Difficulty with math (e.g., balancing checkbook, making change, etc.) _____
- Difficulty telling right from left _____
- Difficulty drawing or copying _____
- Difficulty dressing (not due to motor problems) _____
- Problems finding way around familiar places _____
- Difficulty recognizing objects or people _____
- Parts of my body do not seem as if they belong to me _____
- Not aware of time (e.g., day, season, year) _____
- Highly distractible _____
- Lose my train of thought easily _____
- Difficulty doing more than one thing at a time _____
- Become easily confused and disoriented _____
- Aura (strange feelings) _____
- Don't feel very alert or aware of things _____
- Tasks require more effort or attention _____
- Forget where I leave things (e.g., keys, gloves, etc.) _____
- Forget names _____
- Forget where I am or where I am going _____
- Forget recent events (e.g., breakfast) _____
- Forget appointments or events that happened long ago _____
- More reliant on notes or other people to remind me of things _____
- When driving, I forget routes to well-known places _____
- When driving, I briefly forget where I am driving to _____

60. Any other additional or relevant information not discussed in the above sections? If so, feel free to describe:
