

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/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	_____	_____	_____	_____	_____
Throwing	_____	_____	_____	_____	_____
Scissors	_____	_____	_____	_____	_____
Knife	_____	_____	_____	_____	_____

5. Primary language spoken in the home: _____

Other languages spoken: _____

6. Race/ Ethnicity (Circle one): Caucasian/White Hispanic/Latino(a) American-Indian

Black/African-American Asian/Asian-American Bi/Multiracial Other: _____

7. Where were you born and raised? _____

8. Sex Assigned at Birth (check one):

<input type="checkbox"/> Female	<input type="checkbox"/> Male
<input type="checkbox"/> Intersex, assigned female	<input type="checkbox"/> 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. Please indicate your marital status:

Married: ____ Domestic Partner: _____ Single: ____ Divorced: ____ Widowed: _____ Separated: ____

With whom do you live: _____

12. Do you have children? YES NO

If YES, please give their sex and ages: _____

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

Fewer than 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20+

List any degrees earned (i.e., GED, A.A., B.A., M.A., Ph.D., etc.)? _____

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

Superior Above Average Average Below Average Failing

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

Superior Above Average Average Below Average Failing

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

Superior Above Average Average Below Average Failing

17. Did you ever receive any form of special instructions during your schooling? (For example: tutoring, remedial classes, or special education classes)? YES NO

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

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
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. Have you ever been diagnosed with a neurologic illness or are you presently diagnosed with a medical illness?

YES NO DON'T KNOW

If YES, explain: _____

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

		Year Diagnosed:	Comments:
High Blood Pressure	Yes / No	_____	_____
High Cholesterol	Yes / No	_____	_____
Stroke	Yes / No	_____	_____
Seizure / Epilepsy	Yes / No	_____	_____
Brain Tumor	Yes / No	_____	_____
COVID-19 Infection ^L (Current or Prior)	Yes / No	_____	_____
Sleep Apnea	Yes / No	_____	_____
Heart Attack	Yes / No	_____	_____
Diabetes	Yes / No	_____	_____
Thyroid Problem	Yes / No	_____	_____
Migraines	Yes / No	_____	_____
Cancer	Yes / No	_____	_____
Unintentional weight loss	Yes / No	_____	_____
Vision Problems or Changes	Yes / No	_____	_____
Hearing Problems or Changes	Yes / No	_____	_____

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)

24. 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

25. Have you ever ***previously*** (over 1 yr. ago) had an injury to the head, neck, or spine?

YES NO DON'T KNOW

If YES: How many? _____

What year(s)? _____

Location on head? _____

Did you lose consciousness? YES NO DON'T KNOW

Were you hospitalized? YES NO DON'T KNOW

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

If YES, how were you different? _____

26. **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:

27. Do you currently smoke cigarettes? YES NO

28. Do you currently ever use alcohol? YES NO
How much and how frequently do you drink? _____

Did you ever drink alcohol excessively in the past? YES NO
How much and how frequently did you drink? _____

29. Do you now ever use "street" drugs or prescribed narcotic medications? YES NO
If you use or used drugs, which drugs and how often? _____

Did you ever use "street" drugs or prescribed narcotic medications in the past? YES NO
How much and how frequently did you use? _____

30. 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: _____

31. How would you describe your current mood? _____

32. Have others commented to you about changes in your thinking ability, behavior, personality, or mood? If yes, who and what have they said?

33. Are you current working (i.e., full-time, part-time, consultant, etc.)? YES NO

Job Title: _____ Years at this job: _____

Briefly, describe what your duties/responsibilities: _____

34. Please indicate if you are presently having any of the following cognitive concerns:

Place check in box, if yes

Comments:

- Difficulty figuring out how to do new things _____
- Difficulty thinking as quickly as needed _____
- Difficulty doing things in the right order (sequencing) _____
- Difficulty finding the right word _____
- Slurred speech _____
- Difficulty expressing thoughts _____
- Difficulty understanding what others say _____
- Difficulty understanding what I read _____
- Difficulty with math (e.g., balancing checkbook, making change, etc.) _____
- Difficulty telling right from left _____
- Problems finding way around familiar places _____
- Difficulty recognizing objects or people _____
- 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 _____
- Tasks require more effort or attention _____
- Forget where I leave things (e.g., keys, gloves, etc.) _____
- Forget people's names I've known for a long time _____
- Forget where I am or where I am going _____
- Forget recent events (e.g., breakfast) _____
- Forget events that happened long ago _____
- More reliant on notes or other people to remind me of things _____
- More difficulty navigating while driving to familiar places _____

35. Overall, my cognitive symptoms have developed: Slowly or Quickly

36. My cognitive symptoms occur: Occasionally or Often

37. Over the past 6 months my cognitive symptoms have: Improved or Stayed the Same or Worsened

38. 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

If yes, _____