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. Please indicate your marital status:

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

With whom do you live:_____

7. Do you have children? **YES** **NO**

If YES, please give their sex and ages: _____

8. 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+

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

9. Current Medication List: _____

_____

10. 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				

11. Have you <u>ever</u> been diagnosed with a neurologic illness or are you <u>presently</u> diagnosed with a medical illness not in the above chart?

If so, explain: _____

_____

12. Have you ***<u>recently</u>*** (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

13. 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)

14. 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?_____

15. 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?_____

16. 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: _____

17. How would you describe your current mood? _____

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

_____

_____

19. 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: _____

_____

20. 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, _____

21. 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** _____

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

23. My cognitive symptoms occur: Occasionally or Often

24. Over the past six months my cognitive symptoms have: Improved or Stayed the Same or Worsened

25. Are you experiencing any problems in the following aspects of your life? If so, please explain:

Marital/Family: _____

_____

Housekeeping/Money Management: _____

_____

Driving: _____

_____