NEUROBEHAVIORAL LABORATORY INFORMATION FORM

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

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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. 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.)? _____

_____

9. 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?_____

10. 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?_____

11. 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?_____

12. 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):_____

_____

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

If YES, please describe: _____

_____

14. 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: _____

_____

15. 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).

_____

_____

16. 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: _____

_____

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

Mother:_____ Father:_____

18. 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: _____

_____ .

19. **Do you presently have a diagnosed medical illness? YES NO DON'T KNOW**

If YES, please explain: _____

_____ .

20. Have you ever had a **stroke, brain tumor, seizures**, or been diagnosed with a **neurologic illness**?

YES NO DON'T KNOW

If YES, explain: _____

21. Are you currently on medication? YES NO

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

_____

22. 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: _____

_____

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

If YES, please explain: _____

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

	Circle	Year Diagnosed:	Comments:
High Blood Pressure	Yes / No	_____	_____
High Cholesterol	Yes / No	_____	_____
Cancer	Yes / No	_____	_____
Stroke	Yes / No	_____	_____
COVID-19 Infection	Yes / No	_____	_____
Sleep Apnea	Yes / No	_____	_____
Heart Attack	Yes / No	_____	_____
Diabetes	Yes / No	_____	_____
Thyroid Problem	Yes / No	_____	_____
Migraines	Yes / No	_____	_____
Unintentional weight loss	Yes / No	_____	_____
Dizziness	Yes / No	_____	_____
Excessive Fatigue	Yes / No	_____	_____
Urinary Incontinence	Yes / No	_____	_____
Muscle Weakness	Yes / No	_____	_____
Tremor (indicate body part)	Yes / No	_____	_____
Balance Problems	Yes / No	_____	_____
Blackout spells (fainting)	Yes / No	_____	_____
Numbness/Tingling (indicate where)	Yes / No	_____	_____
Light Sensitivity	Yes / No	_____	_____
Vision Problems/ Changes	Yes / No	_____	_____
Hearing Problems/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)

25. 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? _____

26. 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? _____

27. Has any member of your family been diagnosed with a neurological illness (e.g. Stroke, Parkinson's Disease, Alzheimer's Disease, Huntington's Disease, Multiple Sclerosis, etc.)?

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

If YES, explain: _____

_____ .

28. Do you currently smoke cigarettes? YES NO

Did you smoke cigarettes regularly in the past? YES NO

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

29. 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**

30. 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?): _____

_____

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

_____

32. 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

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

<u>Currently Use</u>: Yes No <u>Use In The Past</u>: 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**

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

_____

35. 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

36. 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	_____	_____

37. 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: _____

_____

38. How would you describe your <u>current mood</u>? _____

_____

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

If YES, please list hospitalizations: _____

_____

40. 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

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

____ Depression
____ Anxiety
____ Schizophrenia
____ Dementia (behavior change, memory loss, confusion)
____ Other problems: _____
____ Alcohol or Drug Problems
____ Sexual Problems
____ Manic Behavior

42. 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: _____

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

YES NO

If YES, describe: _____

_____

44. Please indicate your marital status:

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

With whom do you live:_____

_____

45. Do you have children? YES NO

If YES, please give their sex and ages: _____

_____

46. 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: _____

_____

49. 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_____

_____

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

_____

_____

51. Did you serve in the military? Yes No

If yes, what branch? _____

Date(s) of service: _____

Certifications/Duties:_____

_____

Did you serve in war time? Yes No

If so, what arena? _____

Did you receive injuries of where you ever exposed to any dangerous or unusual substances during your service? Yes No

If yes, explain: _____

_____

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

_____

_____

53. 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 writing letters or words (not due to motor problems)**	_____
❑ **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** _____

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

Marital/Family:

_____

_____

Financial/Legal:

_____

_____

Housekeeping/Money Management:

_____

_____

Driving:

_____

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

56. My cognitive symptoms occur: Occasionally or Often

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