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):

	She/her		He/him/his
	They/them/theirs		

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

	Miss		Mr.
	Mrs.		Mx.
	Ms.		Dr.
	Only use my name (no honorifics)		

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 ***<u>childhood/adolescence</u>*** have **<u>you</u>** 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. Do you presently have a diagnosed medical illness? **YES** **NO** **DON'T KNOW**

If YES, please explain: ______________________________________

23. Have <u>you</u> ever had a **stroke, brain tumor, seizures**, or been diagnosed with a **neurologic illness**?

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

If YES, explain: ______________________________________

24. Are you currently on medication? **YES** **NO**

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

____

25. 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: ___________

____

26. 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 └ (Current or Prior)	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	Yes / No	_______________	_________________________
Light Sensitivity	Yes / No	_______________	_________________________
Vision Problems/ Changes	Yes / No	_______________	_________________________
Hearing Problems/Changes	Yes / No	_______________	_________________________

27. 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)

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

If YES, please explain: ____

29. 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?____

30. 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?____

31. 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:**

32. 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? ___________________

33. 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**

34. 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?): ____

____

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

____

36. 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

37. 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**

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. 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	______	______

41. 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: ____

____

42. How would you describe your <u>current mood</u>? ____

____

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
____ Anxiety
____ Schizophrenia
____ Alcohol or Drug Problems
____ Sexual Problems
____ 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:____
____

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: ____
____

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

55. Are you experiencing any problems in the following aspects of your life? If so, please explain:
Marital/Family:
____
____

Financial/Legal:
____
____

Housekeeping/Money Management:
____
____

Driving:
____

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

57. My cognitive symptoms occur: Occasionally or Often

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

59. 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** ______________________
- ❑ **When driving, I forget routes to well-known places** ______________________
- ❑ **When driving, I briefly forget where I am driving to** ______________________