# 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):**

| | | | |
|---|---|---|---|
| | **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. 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 <u>ever</u> been diagnosed with a neurologic illness or are you <u>presently</u> 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<br>└ (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 ***<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

**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** _____

**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, _____