

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. Please indicate your marital status:

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

With whom do you live: _____

9. Do you have children? YES NO

If YES, please give their sex and ages: _____

10. 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+

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

	Yes / No	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	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)

21. 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

22. 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? _____

23. Have you ever previously 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? _____

24. Do you currently smoke cigarettes? YES NO

Did you smoke cigarettes regularly in the past? YES NO

25. 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? _____

26. 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? _____

27. 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: _____

28. How would you describe your current mood? _____

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

30. 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: _____

31. 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 _____

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

33. My cognitive symptoms occur: Occasionally or Often

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

35. 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, _____