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.

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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 (check one):

	Caucasian/White		**Black/African American**
	Hispanic/Latino(a)		**Asian/Asian-American**
	American-Indian		**Bi/Multiracial**
	Other:		

7. Where were you born and raised? ____

* If born outside of U.S., what year did you move to US? ___________________________

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 first name (no honorifics)		

11. Please indicate your marital status:

	Married		**Domestic Partner**
	Divorced		**Single**
	Separated		**Widowed**

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)? (Check one)

Superior	Above Average	Average	Below Average	Failing

15. How well did you do in high school (Grades 9-12)? (Check one)

Superior	Above Average	Average	Below Average	Failing

16. How well did you do in college (If you did not attend college, please skip)? (Check 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)

	Yes	No	Don't Know
Significant Reading Problems			
Math Problems			
Stuttering			
Withdrawing from other children			
Late acquiring speech (After age 3)			
Learning Problems			
Attention Problems			

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. 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				

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)

23. Have you <u>ever</u> been diagnosed with a neurologic illness or are you <u>presently</u> diagnosed with a medical illness not listed above?

Explain: ____

____

24. Have you ***recently*** (in last 9 months) had a head injury? **Yes No Don't Know**

If yes, fill out below:

Date of Injury?	
Location on head?	
Did you lose consciousness?	

If so, for how long?		**Minutes**		**Hours**
Were you hospitalized?				
If so, for how long?		**Minutes**		**Hours / Days**
Were you different or did you have any problems after your injury?				

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, fill out below:

Date of Injury?				
Location on head?				
Did you lose consciousness?				
If so, for how long?		**Minutes**		**Hours**
Were you hospitalized?				
If so, for how long?		**Minutes**		**Hours / Days**
Were you different or did you have any problems after your injury?				

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 recreational, "street" drugs, or prescribed narcotic medications? **YES** **NO**

If you use drugs, which drugs and how often? ____

Did you ever use recreational, "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: _______________________

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 to familiar places** ______________________

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, ____