Rocky Mountain Movement Disorders Center, P.C.
701 E. Hampden Ave Ste 510 Englewood CO 80113
Phone (303) 357-5455 Fax (303) 357-5459

ADULT HISTORY FORM

Please complete this form and return it prior to your scheduled neuropsychological assessment appointment. Thank you.

Name: _____ **Date of Birth**: _____ **Gender:** _____ **Ethnicity:** _____

Who referred you for the current evaluation? _____

Have you ever had a neuropsychological evaluation in the past? Yes
(*if yes, when?* _____ Name of neuropsychologist _____
Please bring along a copy of the report from this evaluation, if you have it.

What is your understanding of why they referred you for this current evaluation?

_____
_____
_____
_____

What are the questions that you would like the current evaluation to address?

1. _____
_____
_____
_____

2. _____
_____
_____
_____

3. _____
_____
_____
_____

If you have any problems with your thinking, memory, concentration, language, mood, etc., which problems are the **most bothersome** to you right now?

_____
_____
_____

When did you **first start to notice** that you had these symptoms?

_____
_____
_____

Do you think that these symptoms have gotten **worse**, **better**, or **stayed the same?**

_____
_____
_____

If they have gotten worse over time, has the process been **gradual** or **sudden?**

_____
_____

Are your symptoms **interfering with your day-to-day functioning**? If so, please give examples (at work/school, at home, in relationships, in your ability to care for yourself, driving, etc.)

_____
_____
_____
_____
_____

What did you **used to be able to do** that you can no longer do because of your current symptoms?

_____
_____
_____
_____

What types of strategies do you currently use to compensate for your cognitive difficulties? (for example: calendar, Palm Pilot/PDA, sticky notes, lists, reminders from family members/friends, pillbox, etc.)

_____
_____
_____
_____

Medical History:

Please check if you have a history of any of the following:

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Cancer *(if yes, what kind_____)*
- ☐ Infectious disease *(if yes, what kind_____)*
- ☐ Autoimmune disease *(if yes, what kind_____)*
- ☐ Diabetes
- ☐ Lung disease
- ☐ Stomach disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease
- ☐ Arthritis
- ☐ Prolonged infection
- ☐ HIV
- ☐ Hepatitis B or C
- ☐ Lyme disease
- ☐ Head injury *(with loss of consciousness?* No *)*
- ☐ Stroke
- ☐ Brain tumor
- ☐ Seizure
- ☐ Hydrocephalus
- ☐ Tourette's syndrome/tics
- ☐ Lupus
- ☐ Multiple sclerosis
- ☐ Migraine
- ☐ Sleep apnea
- ☐ Restless leg syndrome
- ☐ Dementia
- ☐ Alzheimer's disease
- ☐ Parkinson's disease
- ☐ Tremor
- ☐ Attention deficit disorder
- ☐ Learning disability
- ☐ Major depression
- ☐ Electroconvulsive therapy
- ☐ Psychiatric hospitalization
- ☐ Suicide attempt
- ☐ Anxiety disorder
- ☐ Psychotic disorder
- ☐ Alcohol abuse
- ☐ Drug abuse

Are you currently in treatment for any of the above conditions? (Y/N) If yes, with whom? No _____

Have you ever been hospitalized? (Y/N) No

Have you ever had a ☐ Head CT scan ☐ Brain MRI scan ☐ EEG ☐ Lumbar puncture ☐ SPECT scan ☐ PET scan

Who is your primary care physician? _____

(For women only) Are you post-menopausal? (Y/N) No Are you currently going through menopause (Y/N) No

Psychiatric History and Status:

Are you currently in psychiatric treatment? _____

Are you receiving psychotherapy? _____

Have you ever been treated with medications to treat mood *(if yes, which?* _____)

Other relevant notes pertaining to your psychiatric history: _____

Currently, you would describe your mood as: Happy
If other_____

Current Symptoms: Check if you **currently** experience any of the following:

☐ Sleep problems
- ☐ Trouble falling asleep
- ☐ Trouble sleeping through the night
- ☐ Waking up early in the morning and unable to fall back asleep
- ☐ Snoring
- ☐ Periods of no breathing during sleep

☐ Trouble with driving
☐ Headaches
☐ Pain (*Where?* _____ *How often?* _____)
☐ Vision problems
- ☐ Wear glasses/contacts for reading
- ☐ Wear glasses/contacts for distance
- ☐ Cataracts / Glaucoma / Macular degeneration
- ☐ Other (*please describe*_____)

☐ Hearing problems (*wear hearing aids?* No)
☐ Color blindness
☐ Trouble with sense of smell
(*When did this start?* _____)
☐ Trouble with sense of taste
(*When did this start?* _____)
☐ Tingling or numbness in body
(*Where?* _____)
☐ Balance problems
☐ Weakness
☐ Dizziness
☐ Stomach problems (upset stomach / acid reflux / poor appetite) Upset stomach
☐ Lack of interest in things that used to be pleasurable
☐ Crying more often than usual (or feeling like crying)
☐ Seeing things that aren't there/that others can't see
(*If yes, please describe*: _____
_____)
☐ Hearing things that aren't there/that others can't hear
(*If yes, please describe:* _____
_____)
☐ Lethargy/Fatigue
☐ Feelings of guilt
☐ Feelings of worthlessness
☐ Thoughts of self-harm
☐ Feeling that it is hard to go on living

Current Medications: *feel free to attach a copy of your medication list*

Medication	Dosage	For which condition?

Health Behaviors:

Do you currently drink alcohol? Yes (*If yes, approximately how many drinks per day? ____Per week? ___*)
Have you ever been treated in the past for alcohol use or dependence? Yes (*if yes, when?*_____)
Do you currently use any illicit drugs? Yes (*If yes, please list names below, with frequency*)

Do you currently use caffeine regularly? (*e.g., coffee, tea, chocolate*) Yes If yes, how much per day?_____
Do you exercise regularly? Yes If yes, how often and for how long? _____
What type of exercise? _____

Do you smoke? **Yes/No** Yes If Yes, how many packs per day? _____ How long have you smoked? _____

What time do you usually get to bed at night? _____
What time do you usually wake up? _____

Do you eat a balanced diet? **Yes/No** Yes How many meals a day do you eat? (circle one) **1 / 2 / 3 / 3 +** 3
Do you tend to eat a lot of sugar during the day? **Yes/No** Yes
Do you eat fruits and vegetables every day? **Yes/No** Yes
Have you ever seen a nutritionist? **Yes/No** Yes

Do you use mind/body techniques on a regular basis? **Yes/No** Yes
(*for example: deep breathing, yoga, biofeedback, meditation*)

Do you receive any alternative/non-Western therapies on a regular basis? **Yes/No** Yes
(for example: acupuncture, massage, herbal medicine, etc.)

Family Medical History:

	Currently living?	*Current age(or age at death)*	*Any problems with memory, concentration, thinking, or behavior? (If deceased, any problems when alive?)*
Mother	Yes/No Yes		
Father	Yes/No Yes		

Brothers/Sisters: Please list all brothers and sisters

Age	*M/F*	*Currently living?*	*Any problems with memory or thinking?*
		Yes/No Yes	
		Yes/No Yes	
		Yes/No Yes	
		Yes/No Yes	
		Yes/No Yes	
		Yes/No Yes	
		Yes/No Yes	
		Yes/No Yes	
		Yes/No Yes	

Does/did anyone in your **biological family** have any of the following?

Neurological illness or Dementia

- ☐Alzheimer's disease (*if yes, who?* _____)
- ☐Parkinson's disease (*if yes, who?* _____)
- ☐Another type of dementia (*What type?* _____*Who?* _____)
- ☐Multiple Sclerosis or Lupus (*if yes, who?* _____)
- ☐Epilepsy (*if yes, who?* _____)

Heart Disease or Stroke

- ☐Stroke (*if yes, who?* _____)
- ☐Aneurysm (*if yes, who?* _____)
- ☐Heart Attack (*if yes, who?* _____)
- ☐TIAs / "small strokes" / "mini-strokes" (*if yes, who?* _____)

Developmental Disorder / Learning Disability

- ☐Attention Deficit Hyperactivity Disorder (ADD, ADHD) (*if yes, who?* _____)
- ☐Reading Problems or Dyslexia (*if yes, who?* _____)
- ☐Other Speech or Language Problem (*if yes, who?* _____)
- ☐Developmental or Intellectual Disability (*if yes, who?*_____)
- ☐Autism or Asperger's Syndrome (*if yes, who?* _____)

Mood disorder, Anxiety disorder, Substance abuse

- ☐Depression (*if yes, who?* _____)
- ☐Anxiety (*if yes, who?* _____)
- ☐Tourette's Syndrome (*if yes, who?* _____)
- ☐Bipolar Disorder or Manic Depression (*if yes, who?* _____)
- ☐Schizophrenia (*if yes, who?* _____)
- ☐Alcoholism (*if yes, who?* _____)
- ☐Drug abuse (*if yes, who?* _____)
- ☐Other psychiatric illness (*if yes, who?* _____)

Developmental, Educational and Vocational History:

Where were you born? _____

Where did you grow up? _____

Is English your first language? Y/N (If no, what is your native language? Yes _____)

Were there any complications during your mother's pregnancy with you (Y/N) or your birth (Y/N)? Yes Yes
(if yes, what were the complications? _____)

Are you ☐ right-handed ☐ left-handed ☐ ambidextrous (right and left-handed)?
**☐ did you start out left-handed and become right-handed later?
**If left-handed, are any other family members also left-handed? *(If yes, who*_____)

Check if you were *late* in any of these areas compared to other children your age:

☐ Crawling
☐ Walking
☐ Talking
☐ Reading
☐ Writing
☐ Riding a bicycle

What is the highest level of education that you have achieved?

☐ Pre-high school
☐ High School
☐ Associates Degree
☐ B.A. from 4-year college
☐ Master's Degree
☐ Doctoral Degree
☐ Other professional degree_____

Where did you go to:

High school _____ (any problems noted?)
College/University_____(any problems noted?)
Graduate school _____(any problems noted?)

What were your average grades during the following stages of your education (circle):

Elementary School:	A	B	C	D	F	A
High School:	A	B	C	D	F	A
College/University:	A	B	C	D	F	A
Graduate School:	A	B	C	D	F	A

Academic Difficulties: Check if any of the following were true for you

☐ Held back a grade in school
☐ Tested for special education
☐ Received special education services (i.e., speech therapy, help with reading, tutoring, etc.)
☐ Poor grades
☐ Difficulty with math
☐ Difficulty with writing
☐ Difficulty with spelling
☐ Difficulty reading
☐ Received negative comments (e.g., "class clown" or "Does not work to potential")

What type of occupational work have you done in the past?

_____

What type of occupational work are you doing currently?

_____

Are you currently retired? Yes /No (If yes, when did you retire? _____ Why? Yes _____)

Are you currently on disability? Yes/ No / Applying (If yes, for what reason? Applying _____)

Have you ever received negative feedback from supervisors at work or school because of your current symptoms?

_____

_____

Current Context:

What is your current living situation? ☐ Alone ☐ With partner/spouse ☐ With roommates ☐ With other family ☐ With friends

Family:

Are you currently in a relationship with a partner/spouse? (Y/N) Yes

Are you currently separated or divorced from a partner/spouse or a widow/widower? (Y/N) Yes

Do you have children? (Y/N) If yes, please list ages: Yes

Age	*M/F*	*Living at home?*	*Any health or learning problems?*
		Yes	
		Yes	
		Yes	
		Yes	

Access to healthcare: Do you have adequate access to healthcare at the present time? (Y/N) Yes

(*If no, please elaborate* _____)

Psychosocial supports: Do you have adequate emotional support from others around you? (Y/N) Yes Where do you look for support in your community? (*i.e., partner/spouse, family, colleagues, friends, religious organization*)

_____

Stressors: How would you rate your current level of stress (*none/mild/moderate/severe*)? None What are the most significant sources of stress in your life currently?

_____

Legal History: If your current symptoms are a result of an injury, are you currently involved in a lawsuit? (Y/N) Yes If yes, what is the current status of the lawsuit?

_____

What do you do to help relieve stress? _____

What do you do for fun and/or to relax? _____

Current Examination:

Is there anything else that you want the examiner to know or that is particularly relevant to your neuropsychological evaluation?

_____

_____

Do you have any specific concerns about this evaluation?

_____

_____

THANK YOU