Memphis Neuropsychology, LLC
Pediatric • Adolescent • Adult • Geriatric
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# Initial History Form – Adult and Geriatric Patients

## General Information

Patient's Full Name: ___________________________________________ Today's Date: ______________________

Age: ________ Date of Birth: _____________ Handedness: ☐ R ☐ L ☐ Ambidextrous

Person Completing this Form (if other than patient): ____________________ Relationship to Patient:______________

Phone Numbers: Home ____________________ Work___________________ Cell/mobile ____________________

Full home address: ___________________________________________________________________________

Name and phone number of primary care physician: ____________________________________________________

Name and phone number of specialist: _______________________________________________________________

Who referred you to Memphis Neuropsychology?_______________________________________________________

Name/contact info for attorney if referral is related to legal proceedings: ___________________________________

Please list the reason(s) for your visit: _______________________________________________________________

## General Medical History

Have you had any neuroimaging (e.g., EEG, MRI, CT)? ☐ Yes ☐ No **If yes, please bring radiology reports if available**

List your current medications, including dosage and approximate start date: __________________________________

______________________________________________________________________________________________

Describe any history of psychiatric illness you have had, including any psychiatric treatment ______________________

______________________________________________________________________________________________

Describe any past and current use of alcohol, tobacco, and recreational drugs: _________________________________

______________________________________________________________________________________________

Do you drive currently? ☐ Yes ☐ No **If yes, have there been any incidents in the past couple of years (e.g., confusion, lost, ticket, accident)? Please explain: ____________________________________________________

______________________________________________________________________________________________

**Symptom Survey** - Please check each symptom that applies, and note date of onset if possible:

| **Physical concerns** | **Date of Onset** |
|---|---|
| ◯ Headaches | ____________ |
| ◯ Dizziness | ____________ |
| ◯ Balance problems | ____________ |
| ◯ Urinary problems | ____________ |
| ◯ Bowel problems | ____________ |
| ◯ Strength problems | ____________ |
| ◯ Motor problems | ____________ |

Other physical concerns? _________________________________________________________________________

______________________________________________________________________________________________

**Motor and Coordination**

| | This occurs on your: Right side | Left side | Both sides |
|---|---|---|---|
| ◯ Fine motor problems (managing buttons, pencil, utensils) | ☐ | ☐ | ☐ |
| ◯ Weakness on one side of body | ☐ | ☐ | ☐ |
| ◯ Difficulty holding on to things | ☐ | ☐ | ☐ |
| ◯ Tremor or shakiness | ☐ | ☐ | ☐ |
| ◯ Muscle tics or strange movements | ☐ | ☐ | ☐ |
| ◯ Writing is very small | ☐ | ☐ | ☐ |
| ◯ Writing is very large | ☐ | ☐ | ☐ |
| ◯ Walking more slowly than other people | ☐ | ☐ | ☐ |
| ◯ Balance problems | ☐ | ☐ | ☐ |
| ◯ Difficulty starting to move | ☐ | ☐ | ☐ |
| ◯ Jerky muscles | ☐ | ☐ | ☐ |
| ◯ Muscles tire quickly | ☐ | ☐ | ☐ |
| ◯ Often bumping into things | ☐ | ☐ | ☐ |

◯ Other motor or coordination problems: ____________________________________________

| **Sensory** | **Date of Onset** |
|---|---|
| ◯ Numbness | _____________ |
| ◯ Tingling | _____________ |
| ◯ Visual problems | _____________ |
| ◯ Wear glasses/contact lenses | _____________ |
| ◯ See things that are not there | _____________ |
| ◯ Hearing problems | _____________ |
| ◯ Wear hearing aid | _____________ |
| ◯ Problems with taste or smell | _____________ |

Other sensory concerns? ____________________________________________

**Neurocognitive/Information Processing**

| *Problem Solving* | **Date of Onset** |
|---|---|
| ◯ Difficulty figuring out how to do new things | _____________ |
| ◯ Difficulty figuring out problems that most others can do | _____________ |
| ◯ Difficulty planning ahead | _____________ |
| ◯ Difficulty changing a plan or activity when necessary | _____________ |
| ◯ Difficulty thinking as quickly as needed | _____________ |
| ◯ Difficulty doing things in the right order (sequencing) | _____________ |

Other problem solving problems?____________________________________________

| *Language and Math Skills* | **Date of Onset** |
|---|---|
| ◯ Difficulty finding the right word | _____________ |
| ◯ Slurred speech | _____________ |
| ◯ Difficulty expressing thoughts | _____________ |
| ◯ Difficulty understanding what others say | _____________ |
| ◯ Difficulty understanding what you read | _____________ |
| ◯ Difficulty writing letter or words (not due to a motor problem) | _____________ |
| ◯ Difficulty with math (e.g., balancing checkbook, making change) | _____________ |

Other language or math problems? ____________________________________________

| *Nonverbal skills* | **Date of Onset** |
|---|---|
| ◯ Difficulty telling right from left | _____________ |
| ◯ Difficulty drawing or copying | _____________ |
| ◯ Difficulty dressing | _____________ |

- ◯ Difficulty doing things you used to do automatically (e.g., brushing teeth) _____________
- ◯ Difficulty find way around familiar places _____________
- ◯ Difficulty recognizing objects or people _____________
- ◯ Difficulty decline in my musical abilities _____________
- ◯ Not aware of time/lose track of time _____________
- ◯ Slowed reaction time _____________

Other nonverbal problems? ________________________________________________________________________________

*Concentration/Awareness* **Date of Onset**

- ◯ Highly distractible _____________
- ◯ Lose train of thought easily _____________
- ◯ Mind goes blank a lot _____________
- ◯ Difficulty doing more than one thing at a time _____________
- ◯ Easily confused and disoriented _____________
- ◯ Don't feel very alert or aware of things _____________
- ◯ Tasks require more effort or attention _____________

Other related problems?________________________________________________________________________________

*Memory* **Date of Onset**

- ◯ Forget where you leave things (e.g., keys, purse, etc.) _____________
- ◯ Forget names _____________
- ◯ Forget what you should be doing _____________
- ◯ Forget where you are or where you are going _____________
- ◯ Forget recent events _____________
- ◯ Forget appointments _____________
- ◯ Forget things that happened a long time ago _____________
- ◯ Forget the order of events _____________
- ◯ Forget facts but can remember how to do things _____________
- ◯ Forget faces of people you know _____________
- ◯ More reliant on others to remind me of things _____________
- ◯ More reliant on notes to remember things _____________

Other memory problems? ________________________________________________________________________________

**Mood/Personality** **Date of Onset**

- ◯ Sadness and depression _____________
- ◯ Anxiety or nervousness _____________
- ◯ Stress _____________
- ◯ Sleep problems _____________
- ◯ Excessive snoring _____________
- ◯ Become angry more easily _____________
- ◯ Euphoria (feeling on top of the world) _____________
- ◯ Much more emotional _____________
- ◯ Feel as if you just don't care anymore _____________
- ◯ Easily frustrated _____________
- ◯ Less inhibited (do things you would not do before) _____________
- ◯ Difficulty being spontaneous _____________
- ◯ Change in energy? Loss Gain _____________
- ◯ Change in appetite? Loss Gain _____________
- ◯ Change in weight? Loss Gain _____________
- ◯ Change in sexual interest _____________
- ◯ Lack of interest in pleasurable activities _____________
- ◯ Increase in irritability _____________
- ◯ Increase in aggression _____________

Other changes in mood or personality or in how you deal with people? ________________________________________

________________________________________________________________________________________________

Overall, symptoms have developed? □ Slowly □ Quickly □ Not sure

Over the past 6 months my symptoms have: □ Improved □ Stayed the same □ Worsened □ Not Sure

Please indicate if **you** have a history of any of the following. If yes, please describe and include dates of onset:

**Yes** **No** Head injury ________________________________________________________________

**Yes** **No** Hypertension/High Cholesterol ____________________________________________________

**Yes** **No** Heart Disease _____________________________________________________________

**Yes** **No** Stroke ___________________________________________________________________

**Yes** **No** Seizure/Epilepsy __________________________________________________________

**Yes** **No** Neurological Disorder (e.g., Parkinson's, Dementia) __________________________________

**Yes** **No** Cancer ___________________________________________________________________

**Yes** **No** Diabetes__________________________________________________________________

**Yes** **No** Surgeries _________________________________________________________________

**Yes** **No** Other (e.g., thyroid, autoimmune, menopause) ______________________________________

________________________________________________________________________________

Have others commented on changes in your thinking, behavior, personality, or mood? □ Yes □ No Who, & what have they said?________________________________________________________________________________

**Social and Occupational History**

Highest grade/degree you completed in school: ________________________________________________

Did you require special education? _______________________________________________________

What is your current work status? □ Unemployed □ Employed □ Retired

Past and current occupations _____________________________________________________________

Are you married? □ Yes □ No For how long (list all marriages)? ________________________________

With whom do you currently live? _________________________________________________________

Do you have children? □ Yes □ No What are their ages? _______________________________________

Describe any legal problems you have had: __________________________________________________

How do you spend your time? ____________________________________________________________

**Family History** – Please describe any **family** history of:

Neurological diseases (e.g., Parkinson's, Alzheimer's, multiple sclerosis): ______________________________

________________________________________________________________________________________________

Psychiatric conditions (e.g., depression, anxiety, bipolar, schizophrenia): ______________________________

________________________________________________________________________________________________

Other disorders (e.g., attention deficits, intellectual/learning, speech/language, behavior): __________________

________________________________________________________________________________________________

**Any Additional Comments:**________________________________________________________________

________________________________________________________________________________________________