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.

_____

_____

_____

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 <6 7 8 9 10 11 12 13 14 15 16 17 18 19 20+

List any degrees earned (i.e., GED, B.A., M.A., Ph.D., etc.)? _____

11. 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: _____

_____

12. 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	_____	_____
COVID-19 Infection	Yes / No	_____	_____
Seizure / Epilepsy	Yes / No	_____	_____
Brain Tumor	Yes / No	_____	_____
Sleep Apnea	Yes / No	_____	_____
Heart Attack	Yes / No	_____	_____
Urinary Incontinence	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)

13. Have you ***<u>recently</u>*** (<u>last 9 months</u>) 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 head injury? YES NO DON'T KNOW

If YES, how were you different?_____

*Have you previously had any head injuries in the past (what year):_____

14. 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

15. Do you currently smoke cigarettes? YES NO

Did you smoke cigarettes regularly in the past? YES NO

16. 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?_____

17. 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?_____

18. 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: _____

19. How would you describe your current mood? _____

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

_____

_____

21. 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: _____

_____

22. 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, _____

23. 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** _____

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

25. My cognitive symptoms occur: Occasionally or Often

26. Over the past six months my symptoms have: Improved or Stayed the Same or Worsened

27. Are you experiencing any problems in the following aspects of your life? If so, please explain:

Marital/Family:

_____

Housekeeping/Money Management:

_____

Driving:

_____