

#### John Muir Health—Neuropsychology Services

3480 Buskirk Avenue, Suite 150 Pleasant Hill, CA 94523 (925) 941-4296

Date: \_\_\_\_\_

# \*\*\*\*CONFIDENTIAL\*\*\*\* Please bring with you to your evaluation.

#### **Patient History & Intake Evaluation**

In preparation for your neuropsychological evaluation, please complete this medical history. Although we prefer that you complete the packet yourself, you may ask a family member or friend to assist if needed. Answer questions to the best of your ability. If you have difficulty with any of the questions, leave them blank. We will review this packet at your evaluation.

Patient Name: \_\_\_\_\_

Age:	Birth [	Date:	F	Referred by:		
Sex: □ M	lale 🗆 Female	Race/ Ethnic	city:	Height: _	We	eight:
Glasses:		Hearing aids:		_ Walking	aids:	
Marital Sta	tus: 🗆 Single	☐ Married	□ Separated	□ Divorced	□ Widowed	☐ Common Law
Living with	·					
Handedne	ss (circle one):	Right Handed	I Left Har	nded M	ixed handed	Ambidextrous
Have you o	ever been to ou	r office before	or had a neuro	osychological e	evaluation perfo	ormed before?
their addre	a neuropsycholoss, and phone rotment	number. If you	have a copy or	can get a cop	y of that report	, please bring it to
MEDICAL	HISTORY:					
•	•	` • •	,			ecision-making, olems first began.
<u>Pro</u>	blem (Example	e: forgetting frie	end's names)	When it	<b>began</b> (Exam	ple: 1 year ago)
Have these	e symptoms wo	rsened gotten	better or stave	ed the same si	nce they first b	egan? Explain if
		_	-		•	

Current Treatments (e.g. occupational, speech, or physical therapy, etc.):							
CURRENT ACTIVITIES OF DAILY LIVING AND SOCIA	al Habits:						
What did / do you do to keep yourself busy (i.e. hobbi	es)?						
Are there things you used to do that you are not doing							
When did you stop? Why	?						
Has there been an overall decrease in activities/initiat							
Have you stopped working because of your problems							
Have you stopped driving?	□ Yes	□ No					
Any tickets or accidents this past year?	□ Yes	□ No					
Do you get lost easily when driving?	□ Yes	□ No					
Who manages the finances?							
Problems with balancing checkbook or paying bills? _							
Difficulties with medication? Who manages?							
Difficulties with housekeeping / cooking?							
ADL's (dressing/shaving/make-up/ shower-bathing, et	tc.)						
CURRENT LIVING, LEGAL, AND SOCIAL SITUATIONS							
People you live with:							
Marriage:							
Children:							
Who are the people you rely upon the most?							
Do you feel supported by friends and family?							
Do you have a guardian or conservator? ☐ Yes [	□ No						
Are you now involved in a lawsuit? ☐ Yes ☐ No							

## PRIOR DEVELOPMENT, SOCIAL, AND FAMILY HISTORY:

<u>Family of Origin:</u>			
Where were you born?	Who rais	ed you?	
Number of siblings?			
At what age did you leave home	?		
Educational History:			
What was the highest grade (or	degree) you completed?		
Where did you go to school?			
What kind of grades did you ear	n in high school/college (A's,	B's, etc.)?	
What were your best and worst	classes?		
Were you ever held back in scho	ool or receive any type of spe	ecial education services?	·
If yes, was this for: □ Lea	arning Disability 🛮 ADD/A[	OHD ☐ Other	
WORK AND MILITARY HISTOR	<u>Y:</u>		
What is / was your occupation?			
Current work status: ☐ Emplo	yed □ Unemployed □F	Retired   Disabled	☐ Medical Leave
Did you ever serve in the military	y?	From:	
If yes, what branch?	Honorab	le discharge?	
Tell me where you were working	and for how long at the time	of the illness/accident:	
Kind of work:			
Are you doing volunteer work, o	dd jobs, part-time work:		
Any problems at work prior to yo	our injury or illness?		
What jobs did you have before the	his? Tall ma what you did h	ow long you had the job	and why you loft
Place	Duties	Years/Months	and wify you left.
<u>r iace</u>	<u>Duties</u>	<u>rears/Months</u>	
Why did you leave these jobs?			

CONCERNS R	ELATED TO MIOOD:					
Has your perse	onality changed at all in the	past year?				
Have you expe	erienced depression/anxiety	//other?				
Recent stresso	ors:		· · · · · · · · · · · · · · · · · · ·			
How is your sle	eep?					
About how ma	ny hours of sleep do you us	sually get in a day? _				
Do you nap?	☐ Yes ☐ No For ho	w long:				
How is your ap	opetite?					
Any weight los	s or weight gain?					
evaluation and	experience, if any, have your service to a service the service of		• • • • • • • • • • • • • • • • • • • •	eurological		
		Location	Nature of problem			
ALCOHOL AN	D SUBSTANCE ABUSE HIS	STORY/HABITS:				
Have or do yo	u smoke cigarettes: 🗖 Yes	B □ No □ Neve	r			
Do you chew t	obacco: □ Yes □ No	□ Never				
If yes, how ma	ny per day	If no, w	hen did you quit			
Cups of coffee	per day?	How mi	uch soda per day?			
Alcoholic beve	rages per day?	<u></u>				
When is the la	st time you drank to the poi	nt of intoxication? _				
Was there a p	eriod in your life when you	drank too much alcol	hol? ☐ Yes	□ No		
•	Did you ever try to cut down or stop drinking alcohol? ☐ Yes ☐ No					
Ever had legal problems because of your drinking?						
Did drinking ev	ver get you into trouble with	work/family?	☐ Yes	□ No		
Have you ever	used other drugs in order	to feel good,				
lose weight or	·		☐ Yes	□ No		
	e you used social drugs, lik			ners? Please		

To your knowledge, have you ever had:

Experience or Condition	Ever pro	esent?	When did this begin? (Age or date)	When did this stop? (Age or date)
Attention deficits or hyperactivity	Yes	No		
Balance problems (stumbling, falling)	Yes	No		
Being in Britain, Ireland, Wales, Scotland for 3 or more months, or Europe for 6 or more months, since 1980	Yes	No		
Boxing	Yes	No		
Cancer (type?)	Yes	No		
Changes in or loss of sense of smell	Yes	No		
Chemotherapy (for what condition?	Yes	No		
Chronic lung disease, emphysema, COPD, etc	Yes	No		
Depression, anxiety, mood disorders	Yes	No		
Diabetes	Yes	No		
Disability claim, award, lawsuit, etc.	Yes	No		
Condition(s)				
Eating elk or venison since 1995	Yes	No		
Encephalitis, meningitis, other brain affecting illnesses	Yes	No		
Exposure to heavy metals (arsenic, lead, selenium, mercury, etc.)	Yes	No		
Extended exposure to solvents, paints, gasoline, oils, or pesticides	Yes	No		
Fainting or blacking out	Yes	No		
Family (blood relatives) with memory problems or dementia	Yes	No		
Family (blood relatives) with Parkinson disease, Huntington disease	Yes	No		

Family (blood relatives) with strokes, "hardening of the arteries," cerebrovascular disease	Yes	No	
General anesthesia	Yes	No	
Heading soccer balls	Yes	No	
High blood pressure, hypertension	Yes	No	
Lightening strike, high voltage electric shock	Yes	No	
Low oxygen situation – smoke or fume inhalation, near drowning, etc.	Yes	No	
Migraine headaches	Yes	No	
Muscle weakness (what parts affected?)	Yes	No	
Radiation therapy (for what condition?	Yes	No	
"Seeing stars," being dazed or knocked out or unconscious, head injury, concussion, or coma	Yes	No	
Seizures, epilepsy, convulsions	Yes	No	
Shaking, tremor	Yes	No	
Sleep apnea (or long pauses in breathing while asleep)	Yes	No	
Sleep problems (too much or too little or not refreshing)	Yes	No	
Snoring	Yes	No	
Surgery—what types?	Yes	No	
Steroid use (prescribed or unprescribed), e.g., prednisone	Yes	No	
Stroke, transient ischemic attack (TIA), "light or mini-stroke"	Yes	No	
Tick bites or Lyme disease	Yes	No	

Urine or bowelproblems - losing control or soiling	Yes	No		
High altitude mountain climbing	Yes	No		
Vision problems – double vision, misjudging depth, blind spots other	Yes	No		
List other conditions that may pertain:				
If another person assisted in filling out this	form, ple	ease en	ter information below:	
Name:			Date:	
Relationship to patient:				

## **Medication List**

s, etc.) Drug Name	Dose (amount)	How taken? (oral, injection, inhaled, etc)	Number of times per day	Side effect (if any)
elow any non-John Mu	ir Health doctors	who currently treat	you.	
,	Phone num		Type of Doctor internist, psychi	
	1110110 11011		m.terriies, peyerii	<u> </u>

### **Functional Activities Questionnaire**

The following questionnaire is to be completed by a family member or someone else who knows the patient's current capabilities.

Patie	ent's name	Date						
Rate	er's name	Relationship to patient						
The following items ask you to evaluate the patient's ability to do a variety of very practical skills. Use								
the following ratings scale to indicate how well the patient can do each of the tasks.								
		Normal function; <b>or</b> never did but could do it now	Has difficulty but does by self; or never did but would be difficult to do alone	Requires assistance; or never did, but would require assistance if attempted now	Totally dependent upon others to complete tasks			
		0	1	2	3			
1.	Writing checks, paying bills, balancing a checkbook.							
2.	Assembling tax records, business affairs, or papers.							
3.	Shopping alone for clothes, household necessities, or groceries.							
4.	Playing a game of skill, working on a hobby.							
5.	Heating water, making a cup of coffee, turning OFF the stove.							
6.	Preparing a balanced meal.							
7.	Keeping track of current events.							
8.	Paying attention to, understanding, or discussing a TV show, book, or magazine.							
9.	Remembering appointments, family occasions, holidays, medications, etc.							
10	Traveling out of the neighborhood, driving, arranging to take buses.							