JOHN MUIR HEALTH

John Muir Health—Neuropsychology Services
3480 Buskirk Avenue, Suite 150
Pleasant Hill, CA 94523
(925) 941-4296

******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: ____ Date: ___________

Age: _________ Birth Date: ______________ Referred by: ___________________________

Sex: ☐ Male ☐ Female Race/ Ethnicity: ___________ Height: _________ Weight: __________

Glasses: ___________ Hearing aids: ____________ Walking aids: ______________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common Law

Living with: ____

Handedness (circle one): Right Handed Left Handed Mixed handed Ambidextrous

Have you ever been to our office before or had a neuropsychological evaluation performed before?
Yes No

If you had a neuropsychological evaluation done elsewhere, please give the name of the examiner, their address, and phone number. If you have a copy or can get a copy of that report, please bring it to your appointment.____

____

MEDICAL HISTORY:

Briefly describe what problems (symptoms) with attention, concentration, memory, decision-making, organizing, etc. that you have been having, and approximately when each of the problems first began.

Problem (*Example: forgetting friend's names*) **When it began** (*Example: 1 year ago)*

Have these symptoms worsened, gotten better, or stayed the same since they first began? Explain if necessary:____

____

Current Treatments (e.g. occupational, speech, or physical therapy, etc.):

____

____

CURRENT ACTIVITIES OF DAILY LIVING AND SOCIAL HABITS:

What did / do you do to keep yourself busy (i.e. hobbies)? ______________________________

Are there things you used to do that you are not doing now? ____________________________

____

When did you stop? ____________________ Why? ________________________________

Has there been an overall decrease in activities/initiative? ______________________________

Have you stopped working because of your problems? ☐ Yes ☐ No

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, etc.)

____

____

____

____

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:

Family of Origin:

Where were you born? ______________________ Who raised 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 earn in high school/college (A's, B's, etc.)? ________________________

What were your best and worst classes? ____

Were you ever held back in school or receive any type of special education services?______________

If yes, was this for: ☐ Learning Disability ☐ ADD/ADHD ☐ Other_____________________

WORK AND MILITARY HISTORY:

What is / was your occupation? ____

Current work status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Medical Leave

Did you ever serve in the military? ☐ Yes ☐ No From: ______________________________

If yes, what branch? ________________________ Honorable 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, odd jobs, part-time work: _____________________________________

Any problems at work prior to your injury or illness? _______________________________________

____

____

What jobs did you have before this? Tell me what you did, how long you had the job and why you left.

Place	**Duties**	**Years/Months**
______________________	_________________________	_____________________
______________________	_________________________	_____________________
______________________	_________________________	_____________________
______________________	_________________________	_____________________

Why did you leave these jobs?

____

____

____

CONCERNS RELATED TO MOOD:

Has your personality changed at all in the past year? ______________________________

Have you experienced depression/anxiety/other? ______________________________

Recent stressors: ______________________________

How is your sleep? ______________________________

About how many hours of sleep do you usually get in a day? ______________________________

Do you nap? ☐ Yes ☐ No For how long:______________________________

How is your appetite? ______________________________

Any weight loss or weight gain? ______________________________

What previous experience, if any, have you had with psychiatric, psychological, or neurological evaluation and/or treatment? Please complete information below.

Date	Name of doctor or institution	Location	Nature of problem

ALCOHOL AND SUBSTANCE ABUSE HISTORY/HABITS:

Have or do you smoke cigarettes: ☐ Yes ☐ No ☐ Never

Do you chew tobacco: ☐ Yes ☐ No ☐ Never

If yes, how many per day _______________ If no, when did you quit____________________

Cups of coffee per day? ________________ How much soda per day? __________________

Alcoholic beverages per day? ____________

When is the last time you drank to the point of intoxication? ______________________________

Was there a period in your life when you drank too much alcohol? ☐ Yes ☐ No

Did you ever try to cut down or stop drinking alcohol? ☐ Yes ☐ No

Ever had legal problems because of your drinking? ☐ Yes ☐ No

Did drinking ever get you into trouble with work/family? ☐ Yes ☐ No

Have you ever used other drugs in order to feel good,

lose weight or sleep better? ☐ Yes ☐ No

Do you or have you used social drugs, like cocaine, marijuana, heroin, morphine, others? Please describe:______________________________

____

To your knowledge, have you ever had:

Experience or Condition	Ever present?	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. Condition(s) ___________________	Yes No		
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 bowel ____problems - 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, please enter information below:

Name: ____ Date: ___________________

Relationship to patient: ____

Medication List

CURRENT MEDICATIONS: Include prescriptions, over the counter, Herbals, Patches, Inhalers, Eye Drops, etc.)

Drug Name	Dose (amount)	How taken? (oral, injection, inhaled, etc)	Number of times per day	Side effects (if any)

List below any non-John Muir Health doctors who currently treat you.

Name	Phone number	Type of Doctor (neurologist, internist, psychiatrist, etc.)

Functional Activities Questionnaire

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

Patient's name ____ Date__________________________

Rater'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; **or** never did but could do it now **0**	Has difficulty but does by ***self***; **or** never did but would be difficult to do alone **1**	Requires assistance; **or** never did, but would require assistance if attempted now **2**	Totally dependent upon others to complete tasks **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.	☐	☐	☐	☐