BOSTON NEUROPSYCHOLOGICAL SERVICES, LLC.

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Today's date:

DEMOGRAPHIC INFORMATION

Client's Name:	DOB:	Sex: M / F (circle one)
Telephone: Home Mobile Work		Email:
Street Address:	City:	State: Zip:
Is this location a - House - Other: - Apartment	Length of time at current address: years months	
Primary Language: - English - Other*: * When did you begin speaking English?	Handedness: - Right - Left - Ambidextrous	
How did you hear about our practice? - Doctor (Name): - Internet (Site name):	- Print Media (Name): - Other:	

PRESENTING COMPLAINT

What is the reason for your visit?

____

How long have these difficulties been occurring?

In what setting(s) and how frequently do they occur?

Please rate their impact on overall functioning: - mild - moderate - severe - none

What specific questions would you like to have answered?

1.

2.

3.

CURRENT FUNCTIONING

Please indicate whether you are currently experiencing difficulties in the following areas or whether you have in the past:
(C = Current difficulties; H = History of previous difficulties)

C	H		C	H	
-	-	Binging	-	-	Frequent worries
-	-	Bowel disturbances	-	-	Get lost easily/difficulty navigating
-	-	Clumsiness	-	-	Grief
-	-	Changes in appetite	-	-	Hearing things others do not hear
-	-	Changes in mood/personality	-	-	Inability to make friends
-	-	Changes in sleep pattern	-	-	Insomnia
-	-	Compulsions	-	-	Irritability
-	-	Confusion/Disorientation	-	-	Losing track of time
-	-	Decrease in activity level	-	-	Loss of interest in activities
-	-	Depression	-	-	Muscle tics/twitches
-	-	Difficulty controlling anger	-	-	Nausea
-	-	Difficulty with adapting to change	-	-	Nightmares
-	-	Difficulty with completing an activity	-	-	Numbness
-	-	Difficulty with comprehension	-	-	Obsessions
-	-	Difficulty with expression	-	-	Physical trauma
-	-	Difficulty with math/handling money	-	-	Problems with attention
-	-	Difficulty with planning/organization	-	-	Problems with smell
-	-	Difficulty with reading	-	-	Problems with taste
-	-	Difficulty with writing	-	-	Purging
-	-	Distractibility	-	-	Recurrent dreams
-	-	Dizziness/fainting	-	-	Relationship problems
-	-	Do/say things without thinking	-	-	Restlessness
-	-	Eating more than usual	-	-	Ritualistic behaviors
-	-	Eating less than usual	-	-	Self-harm
-	-	Elevated mood	-	-	Seeing things others do not see
-	-	Emotional trauma	-	-	Significant weight gain/loss
-	-	Excessive energy/can't remain still	-	-	Sexual dysfunction
-	-	Excessive fears/phobias	-	-	Sexual trauma
-	-	Fatigue/low energy	-	-	Shyness
-	-	Fear of other people	-	-	Slowed thinking
-	-	Feel unsafe in a relationship	-	-	Social isolation
-	-	Feelings of guilt	-	-	Suicidal ideas
-	-	Feelings of hopelessness	-	-	Unable to relax
-	-	Feelings of inferiority	-	-	Unusual fears
-	-	Feelings of panic/panic attacks	-	-	Visual Defects
-	-	Feelings of worthlessness	-	-	Weakness
-	-	Feeling others are out to get you	-	-	Other:
-	-	Feeling tense			

Approximately how many hours do you sleep each night? Bed Time: Wake Time:
Do you generally wake during the night? - No - Yes: How often?

Do you smoke cigarettes? - No - Yes: How much and for how long?
Do you drink alcoholic beverages? - No - Yes: How often? How much?
Do you use any of the following recreational drugs (if yes, please indicate current [C] or historical [H] use)?

C	H		C	H	
-	-	Marijuana	-	-	Mushrooms
-	-	Cocaine	-	-	PCP
-	-	Heroine	-	-	Benzodiazepines/Barbituates (Downers)
-	-	Amphetamines (Speed)	-	-	Inhalants/Solvents
-	-	LSD	-	-	Prescription medications
-	-	Ecstasy	-	-	Other:

Do you exercise? - No - Yes: How often and what type(s) of exercise?

BIRTH

Place of birth:	Birth weight: lbs oz

Were you born full term? - Yes - No*
*If No , please describe:

Were there any complications with the pregnancy or delivery?

- Breech positioning
- Labor induced
- High/low blood pressure
- Gestational diabetes
- Dizziness/fainting
- Bleeding
- Emotional stress
- Injury (please describe):
- Cesarean delivery
- Jaundice
- Anemia
- Flu or colds
- Unusually high/low weight gain
- German measles
- Bed rest (please describe):
- Forceps/suction used
- Excessive vomiting
- Rh incompatibility
- Toxemia
- Kidney infection
- Jaundice
- Other (please describe):

Were any of the following used during pregnancy?

- Nicotine		Qty/Freq?	Duration?
- Alcohol		Qty/Freq?	Duration?
- Drugs	Type:	Qty/Freq?	Duration?
- OTC medications	Type:	Dose/Freq?	Duration?
- Prescription medication	Type:	Dose/Freq?	Duration?

Were fertilization techniques used to assist in conception? - Yes - No

Additional comments:

DEVELOPMENT

Please indicate the approximate age at which you reached the following developmental milestones (If unsure, please give your best estimate.):

	Early	On Time	Late	Age, if late
Language Development	-	-	-	________
Gross Motor Skills	-	-	-	________
Fine Motor Skills	-	-	-	

Have you ever had speech therapy, occupational therapy, or physical therapy? - Yes* - No
*If yes, please describe:

OCCUPATIONAL HISTORY

Job History

Company	Position	Dates Employed
1.		
2.		
3.		
4.		

Were you ever fired from a job? - Yes* - No
*If yes, please describe:

Have you served in the military? - No - Yes: Branch and dates of service:
Were you stationed in a combat zone? - No - Yes: Location:

FAMILY/HOUSEHOLD

<table>
<tr><td>Mother
Full name ____
Age ______
- deceased: Age at death ______
Cause of death ______________________
Occupation ____
Highest level of education completed:
- Less than high school
- High School - College
- Master's - Doctorate
Primary language - English - Other:_____________</td><td>Father
Full name____
Age ______
- deceased: Age at death ______
Cause of death______________________
Occupation____
Highest level of education completed:
- Less than high school
- High School - College
- Master's - Doctorate
Primary language - English - Other:____________</td></tr>
<tr><td colspan="2">Where were you raised? __________________________</td></tr>
<tr><td colspan="2">Are you adopted? - Yes - No</td></tr>
<tr><td colspan="2">With whom did you live as a child?
Name Age Relationship Dates
1.
2.
3.
4.</td></tr>
<tr><td colspan="2">Do you have siblings who did not live with you? - Yes* - No
*Please provide the following:
Name Age
1.
2.
3.
4.</td></tr>
<tr><td colspan="2">What is your marital status? - Single - Married - Divorced - Widowed - Domestic Partnership</td></tr>
<tr><td colspan="2">With whom do you live currently?
Name Age Relationship Dates
1.
2.
3.
4.</td></tr>
<tr><td>Have you ever experienced any of the following:
Yes* No
- - Physical, emotional, or sexual abuse as a child
- - Domestic violence/violent assault as an adult
- - Rape
- - Traumatic event</td><td>*Please describe, including how the issue was dealt with:</td></tr>
<tr><td colspan="2">Have you been a witness to violence or abuse? - Yes* - No
*If yes, please describe, including how the issue was dealt with:
____
____
____
____</td></tr>
</table>

MEDICAL HISTORY

Please indicate whether you or a close family member have ever experienced the following difficulties or illnesses:

You	Fam		You	Fam	
-	-	Anemia	-	-	Heart condition
-	-	AIDS	-	-	Hepatitis A
-	-	Alzheimer's Dementia	-	-	Hepatitis B
-	-	Arthritis	-	-	Hepatitis C
-	-	Asthma/Breathing Difficulties	-	-	HIV
-	-	Bruising easily	-	-	Huntington's Disease
-	-	Balance and coordination problems	-	-	Hypertension
-	-	Cancer	-	-	Incontinence
-	-	Cardiovascular Disease	-	-	Kidney disorder
-	-	Cataracts	-	-	Lead poisoning
-	-	Chicken Pox	-	-	Leukemia
-	-	Chronic cough	-	-	Loss of consciousness
-	-	COPD	-	-	Lyme Disease
-	-	Concussion	-	-	Macular Degeneration
-	-	Constipation	-	-	Measles
-	-	Diabetes	-	-	Meningitis
-	-	Dizziness	-	-	Mumps
-	-	Eczema	-	-	Muscle pain
-	-	Emphysema	-	-	Muscle tics/twitches
-	-	Epilepsy	-	-	Neuropathy
-	-	Excessive vomiting	-	-	Pain/strong odor while urinating
-	-	Excessive sleepiness/fatigue	-	-	Parkinson's Disease
-	-	Exposure to mold	-	-	Pneumonia
-	-	Feeding disorder	-	-	Seizures
-	-	Fevers above 104° F	-	-	Shortness of breath
-	-	Fibromyalgia	-	-	Sleep apnea
-	-	Frequent colds	-	-	Stroke
-	-	Frequent diarrhea	-	-	Thyroid disorder
-	-	Frequent ear infections	-	-	Toxin/chemical exposure
-	-	Frequent headaches	-	-	Transient Ischemic Attack (TIA)
-	-	Frequent/intense stomach pain	-	-	Tuberculosis
-	-	Frequent sinus infections	-	-	Urinary tract infection
-	-	Frequent sore throats	-	-	Other:
-	-	Frequent/unexplained rashes			
-	-	Frequent/unexplained sores			

Have you or a family member suffered from any other lengthy illness? - Yes* - No
*If yes, please describe:

Have you ever suffered a head injury (e.g., from motor vehicle accidents, sports, falls, etc.)? - Yes* - No
*Please describe (circumstances; loss of consciousness; any changes in cognitive, behavioral, or emotional functioning):

Have you ever been hospitalized for a physical illness? - Yes* - No
*Please describe:

Have you undergone any operative procedures? - Yes* - No
*Procedure(s) and date(s):

Have you ever been involved in a motor vehicle accident in which you were injured? - Yes* - No
*Please describe (injuries and treatment):

Do you have a genetic disorder? - Yes* - No *Which one?	
When was your last audiological (hearing) exam?	Was it normal? - Yes - No
When was your last vision exam?	Was it normal? - Yes - No
Please indicate any allergies (include foods, medications, animals, environmental, etc.):	

Please indicate all current medications:

Medication Name	Dosage	Reason for Use
1.		
2.		
3.		
4.		

Primary Care Physician name:	Address:	Phone:

SOCIAL/EMOTIONAL/BEHAVIORAL

Current psychiatric diagnoses:

Please list all current and previous outpatient therapists:

Name	Address	Phone	Diagnosis	Dates seen
1.				
2.				
3.				

Did you find treatment to be helpful? - Yes - No*
*Please describe:

Have you ever been hospitalized for depression, anxiety, or another psychiatric disorder? - Yes* - No
*Please describe, including facility name, dates, and reason for treatment:

Psychiatrist's name and address:

Is there a family history of any of the following psychiatric disorders?

- ADHD	- Autism/Asperger's	- Drug abuse/addiction	- Phobia
- Alcoholism	- Bipolar Disorder	- Obessive-Compulsive	- Schizophrenia
- Anxiety	- Clinical Depression	- Personality Disorder	- Other:

EDUCATION

What is the highest level of education you completed?
- Less than high school - High School - College - Master's - Doctorate

Are you currently enrolled at an educational institution? - Yes* - No
*If yes, please provide the following information:
Dates attended: ______________________________
Name of School: ______________________________
Location: ______________________________
Program: ______________________________

Did you ever repeat a grade? - Yes* - No
*Which grade and why?

Were you or a family member ever diagnosed with a learning disability or attention disorder, or do you suspect that you have an undiagnosed learning or attention disorder? - Yes * - No
*Please describe:

Did you ever have an IEP or 504 Plan? - Yes* - No
*Please describe:

What were your strongest subjects?

What were your weakest subjects?

What was your GPA? High school: College:

Were you ever suspended or expelled? - Yes* - No
*Please explain:

ADDITIONAL INFORMATION

Please list any additional treatment providers who currently or previously have seen the child:

Name	Address	Phone	Dates seen	Provider type
1.				
2.				
3.				
4.				

Additional information relevant to the evaluation process/additional comments:

____
____
____
____
____
____
____
____
____