



Carmel Neuropsychology Services, P.C.

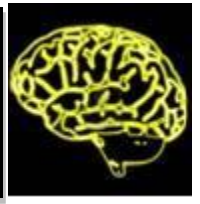
755 West Carmel Drive, Suite 205

Carmel, IN 46032

317-775-8967 (fax) 317-571-0088

CNS@CarmelNeuro.com

www.CarmelNeuro.com



DEVELOPMENTAL HISTORY

For Ages 18+

Please fill out this form to the best of your knowledge. If some questions are not applicable to you, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

Form completed by: _____ Relationship to patient (if applicable) _____

Date form completed: _____

General Information

Patient's Name: _____ Gender: Male Female
Non-Binary

First Middle Last

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Patient's Address: _____
Number and Street City State Zip

Home phone: _____ Cell phone: _____ Work phone: _____

Occupation: _____ Last Grade Completed and Degree (if appropriate): _____

Ethnic/Cultural Background (optional) _____

Primary language spoken in the home: _____ Other language spoken in the home: _____

Marital Status: Never Married Married Unmarried but living in a committed relationship Widowed
 Separated Divorced

Any previous marriages: Yes No If yes, how many times: _____

Number and ages of children: _____

Are they living with the patient? Yes No How many? _____

Patient lives: Alone with no assistance With spouse or partner/family Alone with assistance
 Senior living environment Assisted Living Nursing Home Other: _____

If patient has assistance at home, please describe:

Emergency Contact Name: _____

Address (if different from patient) _____

Work Phone: _____ Home Phone: _____

Referral Information

Who referred you to us/How did you hear about us?

Address of referral source: _____

Phone number of referral source: _____ Fax number of referral source: _____

If you **DO NOT want us to send a copy of our report to the referral source, please mark here

Current Concerns

Please describe the reason you/the patient was referred to our office:

How long have you/the patient had these problems?

What are you hoping to achieve at the completion of this evaluation?

After reading the patient contract, reviewing the website, and reading what to expect, what questions would you like answered about the procedures the patient will be experiencing at our office?

Are you/the patient under any time constraints regarding any procedures, and if so, please describe:

Will any procedures that will be conducted at our offices be part of an ongoing or expected legal case, and if so, please describe (including the name of attorney or firm, court system, or any other relevant information):

Services/Interventions Sought Previously for this Problem

- Medical Evaluation
- Medication
- School Modifications
- Neuropsychological Assessment
- Neurological Exam
- Psychological Counseling or Therapy
- Educational Testing
- Speech/Language Therapy
- Occupational/Physical Therapy
- Psychiatric Exam
- Special Education
- Tutoring

Has the patient had any of the following forms of psychological treatment? If so, how long did it last?

- Individual psychotherapy Yes No Duration and date of therapy?

- Group psychotherapy Yes No Duration and date of therapy?

- Residential treatment Yes No Duration and date of placement?

Are you/the patient currently receiving psychological treatment? If so, with whom and how often?

What else has been tried to do to help you/the patient with these problems, and how effective were these interventions?

Family History

Birth / Adoptive / Foster Mother's Name: _____ Age _____ Education (Yrs) _____
Occupation: _____

Birth / Adoptive / Foster Father's Name: _____ Age _____ Education (Yrs) _____
Occupation: _____

Have there been any major changes within the family life or the patient's living situation that have affected the patient's functioning (e.g., deaths, moves, divorces, loss of job, etc)? No Yes (describe below)

<u>Event</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical History:

Medical Problem	Date of Diagnosis	Description of problem. Please write on the back of this form if necessary

Surgeries: Age: _____ Reason: _____ Where: _____
Other details _____

Surgeries: Age: _____ Reason: _____ Where: _____
Other details _____

Surgeries: Age: _____ Reason: _____ Where: _____
Other details _____

Hospitalizations: Age: _____ Reason: _____ Where: _____
Other details _____

Hospitalizations: Age: _____ Reason: _____ Where: _____
Other details _____

Hospitalizations: Age: _____ Reason: _____ Where: _____

Other details _____

Hospitalizations: Age: _____ Reason: _____ Where: _____

Other details _____

Major accidents or injuries: Age: _____ Type (head, abdomen, fracture, etc.) _____

Other details _____

Major accidents or injuries: Age: _____ Type (head, abdomen, fracture, etc.) _____

Other details _____

Has the patient ever been unconscious? Yes No If yes, please explain: _____

Has the patient ever been exposed to any toxic chemicals? Yes No If yes, please explain: _____

Has the patient had any of the following tests or evaluations?

	Yes	Date (month/ year)	Where	Results
Neurological Evaluation				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know
CT scan of head				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know
MRI scan of head				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know
EEG				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know
Audiology or hearing evaluation				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know
Vision evaluation				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know
Genetic Testing				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know
Other laboratory tests				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know

Family Medical History

Mother: Health, learning, mental health problems, drug or alcohol problems? (please specify) _____

Father: Health, learning, mental health problems, drug or alcohol problems? (please specify) _____

Patient's siblings: Health, learning, mental health problems, drug or alcohol problems? (please specify) _____

Have any of the patient's family members had the following problems/disorders? Please specify the family member's relationship to the patient and whether the relationship is on the maternal (m) or paternal (p) side. Example: aunt (p) = aunt on the father's side.

Family Member(s) Relation to Patient

Family Member(s) Relation to Patient

- | | |
|--|--|
| <input type="checkbox"/> Academic Problems _____ | <input type="checkbox"/> Alcohol/ Drug abuse _____ |
| <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Attention Deficit Disorder _____ |
| <input type="checkbox"/> Autism/ Asperger's _____ | <input type="checkbox"/> Bipolar disorder _____ |
| <input type="checkbox"/> Birth defect _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Cerebral palsy _____ | <input type="checkbox"/> Dementia _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Genetic disorder _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Huntington's chorea _____ | <input type="checkbox"/> Mental retardation _____ |
| <input type="checkbox"/> Migraine headaches _____ | <input type="checkbox"/> Multiple sclerosis _____ |
| <input type="checkbox"/> Muscular dystrophy _____ | <input type="checkbox"/> Obsessive-Compulsive Disorder _____ |
| <input type="checkbox"/> Oppositional/ defiant behaviors _____ | <input type="checkbox"/> Parkinson's Disease _____ |
| <input type="checkbox"/> Physical handicap _____ | <input type="checkbox"/> Physical/ sexual abuse _____ |
| <input type="checkbox"/> Schizophrenia _____ | <input type="checkbox"/> Seizures or epilepsy _____ |
| <input type="checkbox"/> Sickle-cell anemia _____ | <input type="checkbox"/> Speech/ language delay _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Tics/ Tourette's Disorder _____ |
| <input type="checkbox"/> Traumatic Brain Injury _____ | |
| <input type="checkbox"/> Other (specify): _____ | |
| _____ | |

Personal/Social Information

What are the patient's main hobbies and interests?

How often is the patient participating in these activities?

Are there any activities/hobbies the patient has stopped, and if so, why?

Educational History

What was the highest grade completed? Less than High School (____ Grade) GED (Last Grade Completed ____)

High School Associate's Degree Bachelor's Degree Graduate Degree (Specify: _____)

Were there any identified learning disabilities during school years? Yes No

If yes, please describe: _____

Was the patient in special education? Yes No

If yes, for what reason? _____

Any concern about possible difficulties that were not identified? Yes No

If yes, please describe:

Was the patient ever retained in school? Yes No What grade? _____ Why? _____

Occupational History

Present or Most Recent Job (Include job titles, description of work, years employed): _____

Previous Jobs (job titles, description of work, years employed, and reason for change):

Any problems encountered in your work activities? _____

Are you currently involved in a Worker's Compensation case? Yes No

Any previous Worker's Compensation history? Yes No

If yes to either question, provide details: _____

Is the patient currently receiving disability? Yes No If yes, specify condition: _____

Is the patient currently applying for disability? Yes No If yes, specify condition: _____

Emotional Functioning

The Patient:	Not at all	Just a little	Pretty much	Very much	Not applicable
Has decreased interest or pleasure in daily activities					
Has significant weight loss or gain, poor appetite or over-eating without deciding to diet or trying to gain.					
Has difficulty sleeping or is sleeping too much					
Has low energy or fatigue					
Seems excessively agitated___or slowed down___ (check if positive)					
Feels lonely, unwanted, or unloved; complains that “no one loves him or her”					
Has or difficulty making decisions					
Has feelings of hopelessness					
Has recurrent thoughts of death					
Has talked about or attempted suicide					
Has a persistent refusal to go to school in order to stay home with a parent					
Has excessive anxiety or worry					
Feels that worry is difficult to control					
Is restless or feels keyed up or “on edge”					
Is easily fatigued					
Has irritability					
Has muscle tension					
Has difficulty falling or staying asleep, or restless unsatisfying sleep					
Have repetitive behaviors, such as hand-washing, lining things up, checking on things before leaving a room or leaving the house, or mental acts such as a need to keep counting things or repeating words over and over.					
Has thoughts that persist and keep coming back, that cause worry or anxiety					
Has daytime wetting					
Has soiling					

Substance Use

How many alcoholic drinks a day does the patient consume and what kind? _____

At what age did the patient start drinking? _____ When was the patient's last drink of alcohol? _____

Has the patient ever experienced problems due to alcohol consumption, and if so, please describe: _____

Is there a family problem of alcohol abuse, and if so, please describe: _____

Has the patient ever used any of the following:

Marijuana Heroin Cocaine/Crack LSD Ecstasy Methamphetamines Hallucinogens
 Other non-prescribed drugs, please describe: _____

If the patient has used any of the above, please indicate frequency of use, age of first use, and describe any treatment:

Has the patient received any treatment for alcohol or other substance use? Yes No

If yes, please describe: _____

Does the patient smoke cigarettes, pipes, cigars, or chew tobacco? Yes No

If yes, please describe frequency and amount: _____

Legal

Has the patient had any involvement with the legal system? Yes No

Is the patient currently on parole? Yes No

Is the patient current on probation? Yes No

If the patient has had involvement with the legal system, please describe each incident, including the reason for involvement, if the patient was arrested, on what charge the patient was arrested, and what was the outcome of a trial. Please include each length of incarceration.

Other Concerns

Early Childhood history:

Did your birth mother have any complications with her pregnancy with you or the delivery?

No Yes Specify:

Did you meet your developmental milestones on time as a child (i.e. walking on time, talking on time, etc.)?

No Yes Specify:

Please use the following space to write in any additional concerns that were not addressed in this questionnaire.

Thank you for completing this form. It is hoped that this information will help us perform our evaluation with a better understanding of the patient's presenting problems and reason for referral.