HAMPTON ROADS NEUROPSYCHOLOGY
HISTORY FORM

Name:_____Age:_____
Date of Birth:_____/_____/_____ Handedness:(Circle One) Right Left Ambidextrous
Marital Status:_____ Highest level of education:_____
Occupation:_____ Date of Injury: _____/_____/____

Who referred you for this evaluation?_____
Other healthcare providers_____
What would you like to gain from this evaluation?

_____
_____

Do you have any medical conditions? No, or if Yes please list:

_____
_____

Do you have any neurological conditions? No, or if Yes please list:

_____
_____

Do you have any psychiatric conditions? No, or if Yes please list:

_____
_____

Do you have any family history of medical, neurological or psychiatric conditions?
No, or if Yes please list:

_____
_____

Did you have any problems learning in school? No, or if Yes please list:

_____
_____

Social History (please answer mostly yes or mostly no):

Do you exercise on a regular basis?	Yes	No
Do you eat a balanced nutritional diet?	Yes	No
Do you have any problems with your sleep?	Yes	No
Do you have any pain complaints?	Yes	No
Do you engage in mentally stimulating activities?	Yes	No
Do you drink alcohol?	Yes	No
Do you use tobacco?	Yes	No
Do you have concerns about over use of drugs, street or prescription?	Yes	No
Do you have any problems with your spouse or family members?	Yes	No
Do you have any problems with your place of residence?	Yes	No
Do you have any financial stressors?	Yes	No

Functional Ability (please answer mostly yes or mostly no)

Do you need any assistance in shopping?	Yes	No
Do you need any assistance in meal preparation?	Yes	No
Do you need any assistance in housekeeping?	Yes	No
Do you need any assistance in doing laundry?	Yes	No
Do you have any concerns about your driving?	Yes	No
Do you need assistance in taking your medications?	Yes	No
Do you need assistance in managing your finances?	Yes	No
Do you have concerns about your decision making in meeting daily demands?	Yes	No

Check the box beside the reply that is closest to how you have been feeling in the past week.
Don't take too long over you replies: choose your immediate response.

D	A		D	A	
		I feel tense or 'wound up':			**I feel as if I am slowed down:**
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like 'butterflies' in the stomach:**
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often
		I get a sort of frightened feeling as if something awful is about to happen:			**I have lost interest in my appearance:**
	3	Very definitely and quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little, but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			**I feel restless as I have to be on the move:**
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		Not at all		0	Not at all
		Worrying thoughts go through my mind:			**I look forward with enjoyment to things:**
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		I feel cheerful:			**I get sudden feelings of panic:**
3		Not at all		3	Very often indeed
2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		I can sit at ease and feel relaxed:			**I can enjoy a good book or radio or TV program:**
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not Often	2		Not often
	3	Not at all	3		Very seldom

Please check you have answered all the questions