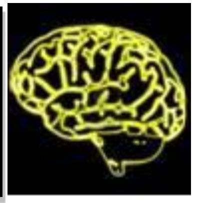
Carmel Neuropsychology Services, P.C.
755 West Carmel Drive, Suite 205
Carmel, IN 46032
317-775-8967 (fax) 317-571-0088 CNS@CarmelNeuro.com www.CarmelNeuro.com



DEVELOPMENTAL HISTORY

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

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 the clinic?

____

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?

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:

Services/Interventions Sought Previously for this Problem

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

Event	Date

Medical/Health History

What was the date the patient's last physical exam? ________________________

Patient's primary physician______________________________________ Phone number __________________________

Vision problem? ☐ Yes ☐ No Date of last vision exam: _________________________________

Hearing problem? ☐ Yes ☐ No Date of last hearing exam: ________________________________

Appetite concerns? ☐ Normal ☐Abnormal ☐ Weight loss/ gain

☐ Difficulty swallowing ☐ Drooling ☐ Gagging

Does the patient have problems falling asleep? ☐ Yes ☐ No

If a yes, how long does it take for him/her to fall asleep? __________ hours

Does the patient wake up in the middle of the night? ☐ Yes ☐ No

If Yes, how many times per night typically? _______________________________

How long does it take for him/her to go back to sleep? ______________________

How many hours total sleep does the patient currently sleep at night? __________

Are there any current concerns related to toileting accidents? ☐ Yes ☐ No

If yes, please describe: ____

Medication History:

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

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				☐ Normal ☐ Abnormal ☐ Don't Know
CT scan of head				☐ Normal ☐ Abnormal ☐ Don't Know
MRI scan of head				☐ Normal ☐ Abnormal ☐ Don't Know
EEG				☐ Normal ☐ Abnormal ☐ Don't Know
Audiology or hearing evaluation				☐ Normal ☐ Abnormal ☐ Don't Know
Vision evaluation				☐ Normal ☐ Abnormal ☐ Don't Know
Genetic Testing				☐ Normal ☐ Abnormal ☐ Don't Know
Other laboratory tests				☐ Normal ☐ Abnormal ☐ 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
☐ Academic Problems	______	☐ Alcohol/ Drug abuse	______
☐ Anxiety	______	☐ Attention Deficit Disorder	______
☐ Autism/ Asperger's	______	☐ Bipolar disorder	______
☐ Birth defect	______	☐ Cancer	______
☐ Cerebral palsy	______	☐ Dementia	______
☐ Depression	______	☐ Diabetes	______
☐ Genetic disorder	______	☐ Heart Disease	______
☐ Huntington's chorea	______	☐ Mental retardation	______
☐ Migraine headaches	______	☐ Multiple sclerosis	______
☐ Muscular dystrophy	______	☐ Obsessive-Compulsive Disorder	______
☐ Oppositional/ defiant behaviors	______	☐ Parkinson's Disease	______
☐ Physical handicap	______	☐ Physical/ sexual abuse	______
☐ Schizophrenia	______	☐ Seizures or epilepsy	______
☐ Sickle-cell anemia	______	☐ Speech/ language delay	______
☐ Stroke	______	☐ Tics/ Tourette's Disorder	______
☐ Traumatic Brain Injury	______		

☐ 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 ☐ Heroine ☐ 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

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.