

For use, first remove all text in red

Normal Control Screen

Personal Data

1. Name: _____
2. Date Interviewed: _____
3. Phone: _____
4. Age: _____
5. Date of Birth: _____
6. Referral Source: _____

Education

1. Number of years of education: _____
2. Highest level of education: _____
3. Unusual trouble with specific subjects in school: (ie: reading, spelling, math) _____
4. Past/present primary job: _____
5. Parents (or primary caregivers) primary job:
 Mom: _____
 Dad: _____
6. Where lived the longest: _____
7. Native English Speaker: _____

Systematic Health

1. Last time saw physician: _____
2. Hospitalizations of any sort:

Indicate the following conditions doctor said you have:

1. Heart Condition:

Attack with loss of consciousness: _____
Amount of time LOC: _____
Weakness, dizziness: _____

2. High Blood

Pressure: _____
well controlled: _____
type of medication and dosage: _____
last reading (max num/denom- 160/90): _____

3. Anemia

Type (**watch for pernicious or sickle cell**): _____

4. Diabetes:

Adult onset: _____
Diet or insulin controlled: _____
History of coma: _____

6. Sleeping problems (ie: apnea) _____

7. Cancer _____

type: _____
metastatic: _____
type of treatment: _____
duration of treatment: _____
remission or cured: _____

8. Hx of serious or recurrent infections (ie: meningitis, herpes)

9. Smoke? Amount: _____

If quit, when and amt before quitting: _____

10 Other (particularly liver disease): _____

(watch indicators of alcohol abuse-ie: cirrhosis, hepatitis or other debilitating conditions- ie: kidney failure)

11. Current medications? What (have them spell it) and dosage:

(watch: pain killers, sleeping pills, allergy pills, tranquilizers, blood thinner, cold, and antibiotics)

12. Recreational Drug use. Do you or have you in the past taken drugs such as amphetamines, barbituates, LSD, marijuana, cocaine...)

What, how often and how much: _____

Neuro/Psychiatric

1. Have you ever been seriously hit on the head ? Circumstance:

Loss of consciousness: _____

How long: _____

What's the last thing you remember before and first thing

after: _____

Memory problems or amnesia after injury: _____

Other symptoms: _____

2. What hand do you write with: _____

3. Have you ever sought counseling where you've received psychiatric medication:

Why? Type of diagnoses: _____

Type of medication and dosage: _____

3. Ever seen a neurologist? Reason: _____

(watch for stroke, TIA's, seizures, Parkinson's, etc)

4. Cognitive Symptoms. Have you ever felt:

Dizziness, fainting spells, loss of memory, frequent or severe headaches. Numb or tingling in body.

If so, when, where, for how long, was it recurring, and at what rate?

Have problems: understanding what you've read, paying attention to what people have said to you, doing simple arithmetic in your

head: _____

If so, is this new, circumstance: _____

Eye Health

1. How is your vision: _____

2. Wear glasses and what is the prescription _____

3. Last time saw an eye doctor: _____

4. Ever have problems with eyes: (ie- cataracts, glaucoma) _____

If so, what has been the treatment? _____

5. Are you colorblind _____

Hearing

1. Last time hearing was tested: _____

2. Have any hearing difficulty: _____

3. Wear hearing aids: _____

Neuro/Psychiatric cont...

1. How much do you drink on a weekly basis: _____

Type of alcohol: _____

At any time in the past was this pattern different? How so? Did it interfere with work:

Have your friends and family ever thought you drank/drink too much:

Have you ever been treated for an alcohol problem:

(watch for blackouts, seizures, dt's)

How much exercise on a weekly basis (what type):

Anything else you might want to add that would be important for us to know about you?
(ie: any handicap that limits your daily activities):
