Blue Ridge Neuropsychological Associates

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BACKGROUND INFORMATION FORM

Please provide the following information about yourself. What you write is confidential. It will help to understand your situation better when we first meet.

Full Name _____

Address: _____

Home phone: (_____) _____ - _____ Work phone: (_____) _____ - _____

Social Security Number? _____-_____-_____ Date of Birth: _____/_____/_____

Sex: Male Female Age: _____

Race: _____ Education: _____

Occupation: _____ Handedness: Right Left Ambidextrous

MEDICAL HISTORY:

1. In your own words, please describe why you are being evaluated: _____

_____

Please list all medications, including vitamins that you are currently taking:

MEDICATION	DOSAGE	DESIRED EFFECT

3. Have you ever needed CPR? Yes No
4. Do you smoke or use other tobacco products? Yes No
5. Do you drink coffee, tea, or caffeinated soda? Yes No
6. Do you drink more than two alcoholic beverages per week? Yes No
7. Have you ever had an EEG, MRI, CT, SPECT or PET Scan? Yes No
8. Have you ever seen a mental health care practitioner for a personal issue? Yes No
9. Have you had any operations? Yes No

   If yes, please specify the type(s) and dates(s) in the following space: _____

_____

K **PLEASE TURN OVER THE PAGE AND CONTINUE**

Below is a list of diseases and symptoms that you may have experienced. Please put a check (☑) in the box(es) that apply to you.

☐ Alzheimer's Disease	☐ Concussion	☐ Hypertension	☐ Polio
☐ Alcoholism	☐ Depression	☐ Hypoglycemia	☐ Psychiatric Illness
☐ Anxiety	☐ Diabetes	☐ Hypoxia	☐ Rheumatic fever
☐ Arteriosclerosis	☐ Dizziness	☐ Kidney Disease	☐ Ringing In Ears
☐ Arthritis/Gout	☐ Drug Addiction	☐ Liver Disease	☐ Seizure/Epilepsy
☐ Attention Deficit	☐ Encephalitis	☐ Lung Disease	☐ Sensory Loss
☐ Auto Accident	☐ Fever (>104°)	☐ Memory Loss	☐ Stroke
☐ Blood Disease	☐ Fibromyalgia	☐ Meningitis	☐ Syphilis
☐ Brain Tumor	☐ Head Injury	☐ Migraines	☐ Tension Headaches
☐ Cancer	☐ Heart Attack	☐ "Mini" Strokes	☐ Thyroid Disease
☐ Cerebral Palsy	☐ Heart Disease	☐ Multiple Sclerosis	☐ TIAs
☐ Chemical Exposure	☐ Heat Exhaustion	☐ "Nerves"	☐ Tourette's Disorder
☐ Chemical Shock	☐ Hit by lightening	☐ Numbness	☐ Tremor
☐ Chronic Fatigue	☐ HIV/AIDS	☐ Parkinson's Disease	☐ Unconsciousness
☐ Chronic Pain	☐ Huntington's Disease	☐ Paralysis	☐ Other:
☐ Coma	☐ Hydrocephalus	☐ Pneumonia	

FAMILY HISTORY:

1. Father's age (or age at death): _____ Health/Cause of death: _____
2. Mother's age (or age at death): _____ Health/Cause of death: _____
3. Siblings: Age Sex State of health

_____ ____ ____ _____

_____ ____ ____ _____

_____ ____ ____ _____

4. Children: Age Sex State of health

_____ ____ ____ _____

_____ ____ ____ _____

_____ ____ ____ _____

5. Who in you family has suffered from the following diseases? (Circle all that apply)

Alzheimer's Disease?	Nobody	Mother	Father	Sibling	Child
Down's Syndrome?	Nobody	Mother	Father	Sibling	Child
Parkinson's Disease?	Nobody	Mother	Father	Sibling	Child
Stroke?	Nobody	Mother	Father	Sibling	Child
Other Neurological Disease?	Nobody	Mother	Father	Sibling	Child
Hypertension?	Nobody	Mother	Father	Sibling	Child
Heart Attack?	Nobody	Mother	Father	Sibling	Child
Heart Disease?	Nobody	Mother	Father	Sibling	Child
Diabetes?	Nobody	Mother	Father	Sibling	Child
Cancer?	Nobody	Mother	Father	Sibling	Child
Depression?	Nobody	Mother	Father	Sibling	Child
Nervous Condition?	Nobody	Mother	Father	Sibling	Child
Psychiatric Disturbance?	Nobody	Mother	Father	Sibling	Child