BOSTON NEUROPSYCHOLOGICAL SERVICES, LLC.

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Today's date: _____ / _____ / 20_____

IDENTIFYING INFORMATION

Client's Name:	Date of Birth:	Preferred name or nickname:
Telephone: Primary Secondary		Sex: ☐ M ☐ F ☐ Other: Preferred pronouns:
Street Address:	City:	State: Zip:
Primary Language: ☐English ☐Other*: *When did you begin speaking English?	Email:	
What professional recommended this evaluation? (name and specialty) ☐ None		
How did you hear about BNS? ☐Google ☐ Other website (Name): ☐Print Media (Name):	☐ The person above recommended BNS ☐ Another professional: ☐ Other:	

REASON(S) FOR EVALUATION

What **concerns or difficulties** led you to seek an evaluation now (or led someone to recommend one)?

When did these issues begin?

Where do they affect you?	When do they affect you?	How serious are they?	Do they seem to be:
☐ At home	☐ Always, no relief ever	☐ Completely disabling	☐ Getting worse
☐ At work	☐ Most of the time	☐ Partially disabling	☐ Getting better
☐ At school	☐ Sometimes	☐ Makes things difficult	☐ Neither
☐ When socializing	☐ Now and then	☐ Manageable	☐ Variable
☐ Other:	☐ Only recently		☐ Not sure

If you have received one or more diagnoses related to these complaints, list them here

Diagnosis	**When diagnosed**	**By whom?**	**Do you agree?**
			☐
			☐
			☐
			☐
			☐
			☐
			☐

What specific questions do you hope this evaluation will answer?

1.

2.

3.

NOTE: You will have the opportunity to elaborate on anything mentioned here with your intake clinician and/or evaluator. If there is anything about which you would like them to ask you for more information, please feel free to indicate that.

TREATMENT HISTORY

What solutions have you already tried? (Continue on separate page if desired)	How helpful was it?

Have you have had any previous **evaluations** for these or related issues? ☐ Yes ☐ No

CURRENT CONCERNS

Please indicate which difficulties concern you. Mark Ⓝ for concerns that bother you **now** (or **recently**). Mark Ⓟ for concerns you have had in the **past**, but no longer have.

Concerns Involving Safety

Ⓝ Ⓟ Thoughts of harming or killing yourself
Ⓝ Ⓟ Self-harm (such as cutting)
Ⓝ Ⓟ Emotional trauma (including PTSD)
Ⓝ Ⓟ Fear in your home or workplace
Ⓝ Ⓟ Violence in your home or workplace

Concerns about Thinking

Ⓝ Ⓟ Ongoing confusion or disorientation
Ⓝ Ⓟ Distinct periods of confusion or disorientation
Ⓝ Ⓟ Frequent distractibility
Ⓝ Ⓟ Can't stop thinking about something
Ⓝ Ⓟ Can't focus on TV, leisure reading, etc.
Ⓝ Ⓟ Can't focus on lectures, news, etc.
Ⓝ Ⓟ Can't focus on work, problem-solving, etc.
Ⓝ Ⓟ Slowed thinking
Ⓝ Ⓟ Problems handling and counting money
Ⓝ Ⓟ Problems managing money (e.g. paying bills)
Ⓝ Ⓟ Get lost often / Difficulty navigating
Ⓝ Ⓟ Can't solve difficult problems
Ⓝ Ⓟ Can't solve easy problems

Concerns about Communicating

Ⓝ Ⓟ Trouble understanding speech in a quiet room
Ⓝ Ⓟ Trouble understanding speech in a noisy room
Ⓝ Ⓟ Trouble expressing yourself clearly
Ⓝ Ⓟ Slow reading
Ⓝ Ⓟ Problems understanding what you read
Ⓝ Ⓟ Difficulty choosing words when writing
Ⓝ Ⓟ Difficulty organizing thoughts

Anxiety Issues

Ⓝ Ⓟ Distinct periods of disabling anxiety
Ⓝ Ⓟ Anxiety most or all of the time
Ⓝ Ⓟ Frequent worries
Ⓝ Ⓟ Panic attacks with known triggers
Ⓝ Ⓟ Unexpected panic attacks
Ⓝ Ⓟ Excessive fear of a specific thing or things
Ⓝ Ⓟ Excessive fear in general
Ⓝ Ⓟ Fear of criticism
Ⓝ Ⓟ Fear of other people (not just of criticism)
Ⓝ Ⓟ Restless
Ⓝ Ⓟ Unable to relax
Ⓝ Ⓟ Unusual fears

Concerns about Perception

Ⓝ Ⓟ Nearsighted
Ⓝ Ⓟ Farsighted
Ⓝ Ⓟ Blind or severely impaired vision
Ⓝ Ⓟ Other visual acuity problem (e.g., astigmatism)
Ⓝ Ⓟ Seeing things others do not see
Ⓝ Ⓟ Difficulty hearing
Ⓝ Ⓟ Hearing things others do not hear
Ⓝ Ⓟ Numbness or tingling
Ⓝ Ⓟ Problems with smell
Ⓝ Ⓟ Problems with tasting food

Eating and Digestion Concerns

Ⓝ Ⓟ Eating too much (or more than usual)
Ⓝ Ⓟ Eating too little (or less than usual)
Ⓝ Ⓟ Unusually picky eater/dislike many foods
Ⓝ Ⓟ Unintended weight gain or loss
Ⓝ Ⓟ Binging
Ⓝ Ⓟ Purging
Ⓝ Ⓟ Irritable Bowel Syndrome/Disease (IBS/IBD)
Ⓝ Ⓟ Crohn's Disease
Ⓝ Ⓟ Frequent diarrhea
Ⓝ Ⓟ Frequent constipation
Ⓝ Ⓟ Other bowel disturbances
Ⓝ Ⓟ Nausea
Ⓝ Ⓟ Frequent vomiting

Chronic Medical Problems

Ⓝ Ⓟ Arthritis / bursitis
Ⓝ Ⓟ Asthma or breathing difficulties
Ⓝ Ⓟ Bruising easily
Ⓝ Ⓟ Diabetes
Ⓝ Ⓟ Epilepsy or history of seizures
Ⓝ Ⓟ Frequent mild illnesses (like colds or rashes)
Ⓝ Ⓟ Migraines
Ⓝ Ⓟ Frequent headaches (other than migraines)
Ⓝ Ⓟ Heart condition
Ⓝ Ⓟ High blood pressure (hypertension)
Ⓝ Ⓟ High cholesterol (hyperlipidemia)
Ⓝ Ⓟ Sleep apnea
Ⓝ Ⓟ History of stroke
Ⓝ Ⓟ Hypothyroidism (low thyroid)
Ⓝ Ⓟ Hyperthyroidism (high thyroid)

Continued on next page

Please indicate which difficulties concern you. Mark Ⓝ for concerns that bother you **now** (or **recently**). Mark Ⓟ for concerns you have had in the **past**, but no longer have.

Mood Concerns

Ⓝ Ⓟ Mood swings (weekly or more often)
Ⓝ Ⓟ Distinct periods of depression
Ⓝ Ⓟ Persistent depression with little relief
Ⓝ Ⓟ Distinct periods of elevated mood
Ⓝ Ⓟ Feeling guilty
Ⓝ Ⓟ Feeling worthless
Ⓝ Ⓟ Grief
Ⓝ Ⓟ Easily irritated by little things
Ⓝ Ⓟ Changed personality

Behavioral Concerns

Ⓝ Ⓟ Compulsive behaviors
Ⓝ Ⓟ Difficulty controlling anger
Ⓝ Ⓟ Often act or speak without thinking
Ⓝ Ⓟ Too much energy/can't remain still
Ⓝ Ⓟ Muscle tics or twitches
Ⓝ Ⓟ Ritualistic behaviors
Ⓝ Ⓟ Trouble adjusting to change
Ⓝ Ⓟ Trouble handling unexpected events
Ⓝ Ⓟ Excessive substance use
Ⓝ Ⓟ Compulsive video game playing
Ⓝ Ⓟ Compulsive gambling
Ⓝ Ⓟ Compulsive sexual activity or porn use
Ⓝ Ⓟ Drug abuse/addiction

Trouble Getting Things Done

Ⓝ Ⓟ Procrastination
Ⓝ Ⓟ Difficulty figuring out how to do a task
Ⓝ Ⓟ Difficulty staying focused on a task
Ⓝ Ⓟ Difficulty completing a task
Ⓝ Ⓟ Perfectionism or compulsively rechecking work
Ⓝ Ⓟ Losing track of time
Ⓝ Ⓟ Forgetting appointments or tasks
Ⓝ Ⓟ Not motivated to do specific things
Ⓝ Ⓟ Not motivated to do much of anything

Social Problems

Ⓝ Ⓟ Difficulty making friends
Ⓝ Ⓟ Difficulty keeping friends
Ⓝ Ⓟ Shy
Ⓝ Ⓟ Dislike being around other people
Ⓝ Ⓟ Difficulty trusting other people
Ⓝ Ⓟ Social isolation

Acute Medical Problems

Ⓝ Ⓟ Concussion
Ⓝ Ⓟ Stroke / Cerebrovascular Accident (CVA)
Ⓝ Ⓟ Transient Ischemic Attack (TIA) or "ministroke"
Ⓝ Ⓟ Head injury

Sleep Problems

Ⓝ Ⓟ Difficulty falling asleep
Ⓝ Ⓟ Difficulty staying asleep
Ⓝ Ⓟ Difficulty waking up
Ⓝ Ⓟ Falling asleep during the day
Ⓝ Ⓟ Nightmares
Ⓝ Ⓟ Recurrent disturbing dreams
Ⓝ Ⓟ Excessive sleepiness or fatigue

Physical Problems

Ⓝ Ⓟ Clumsiness
Ⓝ Ⓟ Dizziness and/or fainting
Ⓝ Ⓟ Fatigue or low energy
Ⓝ Ⓟ Feeling tense
Ⓝ Ⓟ Frequent joint or muscle aches (not disabling)
Ⓝ Ⓟ Chronic disabling pain
Ⓝ Ⓟ Physical weakness
Ⓝ Ⓟ Problems with balance and/or coordination
Ⓝ Ⓟ Back pain

Sexual Concerns

Ⓝ Ⓟ Conflict with spouse or significant other
Ⓝ Ⓟ Distressing lack of interest in sex/loss of desire
Ⓝ Ⓟ Distressing increase in sexual desire
Ⓝ Ⓟ Pain during sex
Ⓝ Ⓟ Often unable to perform during sex
Ⓝ Ⓟ Sexual trauma
Ⓝ Ⓟ Unable to control sexual desires/urges
Ⓝ Ⓟ Erectile dysfunction

Other Concerns

Ⓝ Ⓟ
Ⓝ Ⓟ
Ⓝ Ⓟ
Ⓝ Ⓟ
Ⓝ Ⓟ
Ⓝ Ⓟ
Ⓝ Ⓟ

Please list anyone in your **family** who has problems similar to yours, and what problems they have. Include diagnosed or suspected learning disabilities, attention disorders, developmental disorders, mental illness, etc.

BIRTH AND DEVELOPMENT

If you know of anything unusual about your **birth** or **early childhood health**, please describe it here:

Please give your best estimate as to when you reached the following **developmental milestones**:

	Early	On Time	Late	Age, if late
Language Development	☐	☐	☐	
Gross Motor Skills	☐	☐	☐	
Fine Motor Skills	☐	☐	☐	

Have you ever had ☐**speech therapy**, ☐**occupational therapy**, or ☐**physical therapy**?
☐ Yes, as a child ☐ Yes, as an adult ☐ No
If yes, please describe the **type** of therapy, the **reason** for it, and what the **results** were:

FAMILY/HOUSEHOLD

Where were you raised?
Were you **adopted**? ☐ No ☐ Yes, at **age**

Mother ☐ Biological ☐ Adoptive ☐ Step
Full name:
Age:
Primary language: ☐ English ☐ Other:
Occupation:
Highest level of education completed:
☐ Less than high school
☐ High School ☐ College
☐ Master's ☐ Doctorate
If deceased: Age at death:
Cause of death:

Father ☐ Biological ☐ Adoptive ☐ Step
Full name:
Age:
Primary language: ☐ English ☐ Other:
Occupation:
Highest level of education completed:
☐ Less than high school
☐ High School ☐ College
☐ Master's ☐ Doctorate
If deceased: Age at death:
Cause of death:

Current **marital status**:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership
☐Other (specify): Number of **past** marriages: _____

With whom do you live currently?

Name	Age	Relationship	Since when?
1.			
2.			
3.			
4.			
5.			

Are there problems you have not listed above that your family or friends think you have? If so, please describe them. (This can help us clarify whether their concerns are justified or not.)

MEDICAL HISTORY

Please list any major medical or psychological **illnesses**, **disorders** (including genetic), or **serious injuries** you currently have or have had in the past. (Continue on a separate page if needed.)

Have you ever experienced any of the following? If so, please describe briefly what happened and how the issue was dealt with. Use a separate page if needed.

- ☐ Physical, emotional, or sexual abuse as a child
- ☐ Domestic violence/violent assault as an adult
- ☐ Rape or sexual assault
- ☐ Traumatic event
- ☐ Motor vehicle accident

Have you been a witness to violence or abuse? ☐ Yes* ☐ No

*If yes, please describe, including how the issue was dealt with (continue on a separate page if needed):

Head Injuries: ☐ None ☐One or more (describe below):

Age	Cause	Effects (loss of consciousness, nausea, behavioral changes, mood changes, confusion, etc.)

Hospitalizations in past 10 years: ☐ None ☐One or more (describe below):

Age/Date	Reason	Results

Operations requiring anesthesia: ☐ None ☐One or more (describe below):

Age/Date	Reason	Results

Have you had a **brain MRI** or **CT scan of the head**? ☐ Yes ☐ No

If yes, when and where?

What findings were noted?

GENERAL HEALTH

Handedness: ☐ Right ☐ Left ☐ Ambidextrous

About how many hours do you **sleep** each night? Bed Time: Wake Time:
Do you usually **wake** during the night? ☐ No ☐ Yes: How many times?
What do you usually do **right before bed**?

How often and when do you experience:
Urinary incontinence: ☐ Never ☐ Sometimes ☐ Often ☐ While sleeping ☐ While awake
Bowel incontinence: ☐ Never ☐ Sometimes ☐ Often ☐ While sleeping ☐ While awake

Do you **exercise**? ☐ No ☐ Yes: What type(s) of exercise? How often?

How many **meals** do you typically eat per day?

What **foods** do you typically eat? (Include snacks.)	What foods do you **avoid**? Why?

Please list your current **medications** (continue on a separate page if needed):

	Medication Name	Dosage	Reason for Use
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Please list all **medical** or other **professionals** you have worked with on issues related to this evaluation. Mark Ⓝ for those you see **now** (or **recently**). Mark Ⓟ you saw in the **past**, but no longer do.

Now/Past	**Profession**	**Name**	**Location**	**Phone**	**Fax (if available)**
Ⓝ Ⓟ	Primary care				
Ⓝ Ⓟ	Psychiatrist				
Ⓝ Ⓟ	Neurologist				
Ⓝ Ⓟ	Therapist				
Ⓝ Ⓟ					
Ⓝ Ⓟ					
Ⓝ Ⓟ					
Ⓝ Ⓟ					

When was your last **hearing** exam? Results:

When was your last **vision** exam? Results:

Do you wear ☐**glasses** or ☐**contact lenses**?
☐Neither ☐Only for reading ☐ Only for distance ☐ Always Vision: 20/_____

Please indicate any **allergies** (include foods, medications, animals, environmental, etc.):

Do you keep one or more **weapons** such as firearms in your home? ☐ Yes ☐ Yes, safely locked ☐ No

GENERAL HEALTH (continued)

Non-medical substance use	Approximately when did you First use it?	Last use it?	How often?	How much/What method?
Alcohol				
Tobacco				
Caffeine				
Marijuana				
Cocaine				
Heroin				
Prescription meds (not as prescribed)				

Other, such as amphetamines (speed), LSD, Ecstasy/MDMA, Mushrooms, PCP, Benzos/Barbituates (Downers), Inhalants/Solvents:

EDUCATION

What is the highest **level of education** you completed?
☐ Less than high school ☐ High School ☐ College ☐ Master's ☐ Doctorate

Are you **currently** enrolled at an educational institution? ☐ Yes ☐ No
Name of school:
Location:
Program:
Dates attended:

Did you ever **repeat a grade**? ☐ Yes ☐ No Which grade(s)?
If yes, why?

Did you ever participate in **Special Education** (including having an IEP or 504 plan)? ☐ Yes ☐ No
If yes, please describe:

What were your **strongest subjects**?

What were your **weakest subjects**?

What were your usual grades or GPA? High school: College:

Were you ever suspended or expelled? ☐ Yes ☐ No
If yes, please explain:

OCCUPATIONAL HISTORY (continue on separate page if necessary)

Employer	Role	Dates employed	Reason for leaving

Have you served in the **military**? ☐No ☐Yes
Branch and dates of service:

Were you stationed in a **combat** zone? ☐ No ☐Yes
Location:

ADDITIONAL INFORMATION

What else would you like the psychologist performing your evaluation to **ask you** or to **know about you**?