Upcounty Neuropsychology, LLC

NEW ADULT PATIENT PACKET

Name (incl. nickname)		DOB	Today's Date
Age	Marital Status	Sex	Race
Address		Mobile Phone	
		Home Phone	
		Work Phone	
E-mail			
Current Occupation			
Current Employer			
Previous Jobs			

Insurance Information:

Policy Holder's Name	
Primary Insurance	
Policy/Identification Number	
Group Number	Insurance Telephone Number

Who Referred You:

_____ Primary Care Physician _____

_____ Hospital/Emergency Department _____

_____ Psychiatrist _____

_____ Specialist _____

_____ Other _____

Presenting Concerns and Psychiatric History:

(1) Briefly describe your current concerns:

(2) How long have these been of concern to you?

(3) Have you ever received an evaluation or treatment of the current problem or similar problems? If yes, when and with whom?

(4) Have you received any other mental health, psychological, or psychiatric services before?

Home:

Please provide the names, ages, and relationships of all those persons who are living with you:

Name:	Age:	Relationship:
(1)		
(2)		
(3)		
(4)		
(5)		

Educational History:

(1) Highest degree obtained: _____

(2) Name of school/college: _____

(3) Did you have any academic or behavioral problems in school? If yes, please describe.

(4) Did you receive any special education services?

(5) Have you ever repeated a grade or been “held back” for any reason? If yes, why?

(6) Did you make friends easily?

Medical Information:

Physician	Phone	Address
Specialist	Phone	Address

(1) Date of last physical examination _____

(2) Please list all current prescription medications:

Medication:	Dosage:	Frequency:	Date Began

(3) Please list current over-the-counter medications or supplements:

(4) Current medical problems:

(5) Have you *ever* had any of the following medical problems?

Anemia	Y or N	Head trauma	Y or N
Asthma/respiratory problems	Y or N	High blood pressure	Y or N
Cancer	Y or N	High cholesterol	Y or N
Cardiac disease	Y or N	HIV/AIDS	Y or N
Chronic pain	Y or N	Kidney disease	Y or N
Chronic fatigue	Y or N	Liver problems	Y or N
Diabetes – Type 1	Y or N	Skin problems	Y or N
Diabetes – Type 2	Y or N	Stomach or intestinal problems	Y or N

Epilepsy or seizures	Y or N	Thyroid disease	Y or N
Fibromyalgia	Y or N	Other (please specify)	Y or N

(6) Do you have any history of hospitalizations or surgeries? If yes, for what reason? When?

(7) Please indicate whether anyone in your immediate and/or extended family (e.g., grandparents, aunts, uncles, and cousins) have had any of the following illnesses or conditions. Also indicate the person's relationship to you:

		Relationship to You
ADHD/ADD	Y or N	
Autism	Y or N	
Learning problems	Y or N	
Alcoholism	Y or N	
Other substance abuse	Y or N	
Cancer	Y or N	
Cardiac disease	Y or N	
Diabetes	Y or N	
Depression	Y or N	
Bipolar disorder	Y or N	
Schizophrenia	Y or N	
"Nervous breakdown"	Y or N	
Suicide	Y or N	

Substance Use:

(1) Do you drink alcohol? Yes _____ No _____

If yes, how much? _____ How often? _____

(2) Do you use recreational substances? Yes _____ No _____

If yes, what kind? _____

How much? _____ How often? _____

Developmental History:

(1) During pregnancy, did your mother experience any medical or mental health problems? If yes, please describe.

(2) Were there any complications related to your birth (e.g., long labor, forceps delivery, C-section, and prematurity)? If yes, please describe.

(3) Birth weight (approximate): _____

(4) Were there any medical problems during your early infancy?

(5) Were there any problems in your early development (e.g., walked late, delayed speech, failure to thrive)? If yes, please elaborate.

Other:

What are your favorite activities or hobbies?

Have you ever been in trouble with the law? If yes, briefly describe.

Is there any other information that might assist in understanding you?