NEUROBEHAVIORAL ASSOCIATES

Specializing in Attention, Learning, and Neurodevelopmental Differences

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ADULT

Neuropsychological Consultation & Evaluation
Forensic Evaluation
Referral Services
Educational Consultation

Welcome to NeuroBehavioral Associates

We are pleased to offer you and your family a full range of comprehensive neuropsychological and psychological assessment services. The neuropsychological evaluation is one method of diagnosing developmental, degenerative, and acquired disorders of brain function. Neuropsychological evaluation can help determine the impact and consequences of brain-based disorders. The purpose of the neuropsychological examination is to assess how dysfunction of the brain may relate to problems in thinking, learning, emotions, and/or behavior.

We specialize in the assessment of **Attention, Learning,** and **Neurodevelopmental Differences**. Our evaluation includes intellectual assessment, assessment of attention and concentration, visual motor skills, memory and processing skills, executive abilities, and emotional/personality functioning.

You have an appointment for neuropsychological consultation and/or evaluation with:

Dr. _____

Consultation (if needed) Date: _____ Time: _____

Evaluation Date: _____ Time: _____

Your full financial obligation to our office at this time is $ _____. **The full payment is due at the time of your visit.** You may pay by cash, personal check, money order, or credit card. We do not accept debit cards. Additional services, such as attendance at IEP or 504 meetings, school observations and document preparation are billed separately.

We will provide information to permit insurance submission. We ask that you confirm with your insurance company if pre-authorization is necessary prior to your appointment.

Please fill out the enclosed history form and bring it with you at the time of the appointment. Also, please bring **photocopies of relevant academic or medical records, for our files** as well. **Should you need to cancel your appointment for any reason, please notify this office at least 48 hours in advance**. If notification is not made in advance, you may be charged for one hour of service.

We look forward to serving you.

Thank you,
Vincent P. Culotta, Ph. D., ABN
Licensed Psychologist
Neuropsychologist

Visit our website at www.nbatests.com !

www.facebook.com/nbacolumbia

5550 Sterrett Place Suite 300 Columbia, MD 21044 Phone: 410-772-7155 FAX 410-772-7156

ADULT HISTORY FORM

Patient's Name: _____ Date: _____

Address (Street, City, ST, Zip): _____

_____

Patient's phone: (H) _____ (W) _____

Guardian's phone: (H) _____ (W) _____

Age: _____ Birthdate: _____ Sex: _____ Education: _____

Ethnic or Racial Background: _____ Secondary Language: _____

Job Title: _____

School Attending (if any): _____

Hand Used for Writing: (check one) Right hand _____ Left Hand _____

Primary Care Physician: _____ Phone: _____

Referral Source: _____ Phone: _____

REASON FOR THIS CONSULTATION: _____

_____

_____

_____

Has any school or Professional Given any of the following Diagnoses?

Diagnosis	By Whom?	When?
Communication Disorder:	_____	_____
Autism/PDD:	_____	_____
Intellectual Disability:	_____	_____
ADD/ADHD:	_____	_____
Emotional Disturbance:	_____	_____
Reading Disability:	_____	_____
Math Disability:	_____	_____
Writing Disability:	_____	_____
Coordination Disorder:	_____	_____

Hearing Impaired: _____ _____

Visually Impaired: _____ _____

Other: _____ _____ _____

SYMPTOM SURVEY:

For each symptom that applies, place a check on the line. Check the "NEW" line if the symptom has been occurring for less than a year, and check the "OLD" line if the symptom has been occurring for more than a year.

PROBLEM SOLVING:

NEW	OLD	
_____	_____	Difficulty figuring out how to do new things
_____	_____	Difficulty planning ahead
_____	_____	Difficulty figuring out problems that most other people can do
_____	_____	Difficulty thinking as quickly as needed
_____	_____	Difficulty doing things in the right order (sequence problems)
_____	_____	Difficulty verbally describing the steps involved in doing something
_____	_____	Difficulty changing a plan or activity when necessary
_____	_____	Difficulty completing an activity in a reasonable amount of time
_____	_____	Difficulty doing more than one thing at a time
_____	_____	Difficulty switching from one activity to another
_____	_____	Easily frustrated
_____	_____	Other problem solving difficulties: _____

SPEECH, LANGUAGE, and MATH SKILLS:

NEW	OLD	
_____	_____	Difficulty finding the right word to say
_____	_____	Difficulty understanding what others are saying
_____	_____	Unable to speak
_____	_____	Difficulty staying with one idea
_____	_____	Difficulty writing letters or words (not due to motor problems)
_____	_____	Slurred speech
_____	_____	Odd or unusual speech sounds
_____	_____	Difficulty with math (e.g. checkbook balancing, making change, etc.)
_____	_____	Difficulty understanding what I read
_____	_____	Difficulty spelling
_____	_____	Other: _____

NONVERBAL SKILLS:

NEW	OLD	
_____	_____	Difficulty telling right from left
_____	_____	Difficulty doing things I should automatically be able to do
_____	_____	Problems drawing or copying
_____	_____	Difficulty dressing (not due to physical activity)
_____	_____	Problems finding my way around places I've been to before
_____	_____	Difficulty recognizing objects or people
_____	_____	Parts of my body do not seem as if they belong to me
_____	_____	Unaware of things on one side of my body: Right ____ Left: ____
_____	_____	Decline in my muscle abilities
_____	_____	Not aware of time (e.g. time of day, season, year)
_____	_____	Slow reaction time
_____	_____	Other: _____

MEMORY:

NEW	OLD	
_____	_____	Forgetting where I leave things (e.g. keys, gloves, etc.)
_____	_____	Forgetting names
_____	_____	Forgetting what I should be doing
_____	_____	Forgetting where I am or where I am going
_____	_____	Forgetting events that happened quite recently (e.g. my last meal)
_____	_____	Forgetting events that happened long ago (months or years)
_____	_____	Need someone to give me a hint so I can remember things
_____	_____	Relying more and more on notes to remember things
_____	_____	Forgetting the order of things (e.g., when cooking, etc.)
_____	_____	Forgetting facts, but I can remember how to do things
_____	_____	Forgetting how to do things, but I can remember facts
_____	_____	Forgetting faces of people I know (when they are not present)
_____	_____	Frequently forgetting appointments
_____	_____	Other: _____

MOTOR AND COORDINATION:

NEW	OLD		Check the side this occurs on: Right	Left	Both
_____	_____	Fine motor control problems	_____	_____	_____
_____	_____	Weakness on one side of my body	_____	_____	_____
_____	_____	Difficulty holding onto things	_____	_____	_____
_____	_____	Tremor or shakiness	_____	_____	_____
_____	_____	Muscle tics or strange movements	_____	_____	_____
_____	_____	My writing is very small			
_____	_____	My writing is very large			
_____	_____	I walk more slowly than other people			

NEW	OLD	
_____	_____	I feel stiff
_____	_____	Balance problems
_____	_____	Difficulty starting to move
_____	_____	Jerky muscles
_____	_____	Muscles tire quickly
_____	_____	Often bumping into things
_____	_____	Other: _____

SENSORY:

NEW	OLD		Check the side this occurs on: Right	Left	Both
_____	_____	Loss of feeling or numbness	_____	_____	_____
_____	_____	Tingling or strange skin sensations	_____	_____	_____
_____	_____	Difficulty telling hot from cold	_____	_____	_____
_____	_____	Problems seeing on one side	_____	_____	_____
_____	_____	Blurred vision	_____	_____	_____
_____	_____	Blank spots In vision	_____	_____	_____
_____	_____	Brief periods of blindness	_____	_____	_____
_____	_____	See “stars” or flashes of light	_____	_____	_____
_____	_____	Double vision			
_____	_____	Difficulty looking quickly from one object to another			
_____	_____	Need to squint or move closer to see clearly			
_____	_____	Losing hearing			
_____	_____	Ringing in my ears or hearing strange sounds			
_____	_____	Difficulty tasting food			
_____	_____	Difficulty smelling			
_____	_____	Smelling strange odors			
_____	_____	Other: _____			

PHYSICAL:

NEW	OLD	
_____	_____	Headaches
_____	_____	Dizziness
_____	_____	Nausea or vomiting
_____	_____	Urinary Incontinenece
_____	_____	Loss of bowel control
_____	_____	Excessive Tiredness
_____	_____	Other: _____

BEHAVIOR:

NEW	OLD		Rate how severe: Mild	Moderate	Severe
_____	_____	Sadness or depression	_____	_____	_____
_____	_____	Anxiety or nervousness	_____	_____	_____
_____	_____	Stress	_____	_____	_____
_____	_____	Sleeping problem	_____	_____	_____
_____	_____	Become angry more easily			
_____	_____	Euphoria (feeling on top of the world)			
_____	_____	Much more emotional (e.g. cry more easily)			
_____	_____	Feel as if I just don't care anymore			
_____	_____	Doing things automatically (without awareness)			
_____	_____	Less inhibited (do things I would not do before)			
_____	_____	Difficulty being spontaneous			
_____	_____	Change in eating habits: _____			
_____	_____	Change in interest in sex: _____			
_____	_____	Other: _____			

Overall, my symptoms have developed: ____ Slowly ____ Quickly

My symptoms occur: ____ Occasionally ____ Often

Over the past six months my symptoms have: ____ Stayed about the same ____ Worsened

In summary, there is:

____ Definitely something wrong with me

____ Possibly something wrong

____ Nothing wrong

EARLY HISTORY:

You were born: On time: ____ Prematurely: ____ Late: ____

You weight at birth was: _____lbs. _____oz.

Mother's weight gain during pregnancy: _____ lbs.

What was your mother's age at your birth? ____ Father's age? ____

Were there any problems associated with your birth (e.g. oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g. need for oxygen, special equipment used, convulsions, illness, etc.)? ___ YES ___ NO
If yes, please describe:

_____

_____

_____

Check all that applied to your mother while she was pregnant with you:

_____ Accident
_____ Alcohol Use
_____ Cigarette Smoking
_____ Illegal Drug Use (marijuana, speed, cocaine, LSD, etc.)
_____ Illness (toxemia, diabetes, high blood pressure, infection, Rh incompatability, etc.)
_____ Poor nutrition
_____ Psychological problems
_____ Other problems: _____

List all the medications (prescribed or over-the-counter) your mother took while pregnant:

_____

During her pregnancy, did your mother live near a polluted area (e.g. toxic waste dump) or other hazardous area (nuclear plant, industrial area, pesticide sprayed area, etc.)?
___ YES ___ NO If yes, please describe:

_____

_____

Rate your developmental progress as it has been reported to you by checking one description for each area:

	Early	Average	Late
Walking	_____	_____	_____
Language	_____	_____	_____
Toilet training	_____	_____	_____
Overall Development	_____	_____	_____

As a child, did you have any of these conditions? (check all that apply)

_____ Attention problems	_____ Head injury	_____ Muscle tightness or weakness
_____ Clumsiness	_____ Hearing problems	_____ Speech problems
_____ Developmental Delay	_____ Hyperactivity	_____ Vision problems
_____ Frequent ear infections	_____ Learning disability	_____ Other: _____

MEDICAL HISTORY:

Check all the conditions that were diagnosed when you were a child. Add any helpful details (age at diagnosis, treatment provided, etc.).

____ Allergies	____ Epilepsy or seizures	____ Pneumonia
____ Asthma	____ Fevers (104° or higher)	____ Poisoning
____ Brain infection or disease	____ Heart problems	____ Polio
____ Cancer	____ Immune system disease	____ Rheumatic fever
____ Cerebral palsy	____ Kidney problems	____ Scarlet fever
____ Chicken pox	____ Lung (respiratory disease	____ Tuberculosis
____ Colds (excessive)	____ Measles	____ Venereal disease
____ Diabetes	____ Meningitis	____ Whooping cough
____ Encephalitis	____ Oxygen deprivation	____ Other: _____

As a child, were you exposed to excessive amounts of lead (e.g. eating paint chips, living next to high concentrations of automobile exhaust fumes, etc.)? ___ YES ___ NO
If yes, please explain:

_____

As a child, did you have an accident which required a hospital visit? ___ YES ___ NO
If yes, please explain:

_____

Did you ever suffer a serious injury to your head? ___ YES ___ NO
If yes, please explain:

_____

_____

How would you describe you nutrition as a child and adolescent?

___ Excellent ___ Average ___Poor

List the medications that were regularly given to you as a child:

Medication	Reason for the Medication
_____	_____
_____	_____
_____	_____

Check all that currently apply.

____ AIDS, ARC, or HIV +	____ Heart disease	____ Parkinson's disease
____ Allergies	____ Huntington's disease	____ Polio
____ Arteriosclerosis (artery disease)	____ Hypertension	____ Psychiatric problems
____ Arthritis	____ Kidney disease	____ Radiation exposure or therapy
____ Blood disorder	____ Liver disease	____ Senility (Dementia)
____ Brain disease or infection	____ Lung (respiratory) disease	____ Stroke or TIA
____ Cancer or chemotherapy	____ Malnutrition	____ Thyroid disease
____ Diabetes	____ Meningitis	____ Venereal disease
____ Hazardous substance exposure	____ Multiple sclerosis	____ Other: _____

List any medications that you currently take (prescription and over-the-counter) and their dosages.

_____

_____

_____

Do you have epilepsy or a seizure disorder? ___ YES ___ NO

If yes, check the type you have been diagnosed with.

PARTIAL	GENERALIZED	___ UNCLASSIFIED TYPE
___ Simple partial (Jacksonian)	___ Absence (Petit mal)	
___ Complex partial (Psychomotor)	___ Myoclonic	
___ Partial evolving into generalized	___ Clonic	
	___ Tonic	
	___ Tonic-clonic (Grand mal)	
	___ Atonic	

___ I HAVE A SEIZURE DISORDER BUT DON'T KNOW WHICH TYPE.

Please describe it: _____

Please describe all of the hospitalizations you have had: _____

_____

_____

_____

FAMILY HISTORY

The following questions deal with your biological family.

MOTHER

What is your mother's name (include maiden name)? _____

Is she alive? ___ YES ___ NO If deceased, what was the cause of death? _____

Mother's occupation: _____

Mother's level of education: _____

Mother's hobbies: _____

Does you mother have a known or suspected learning disability? ___ YES ___ NO

If yes, please describe: _____

Briefly describe your mother's health history: _____

_____

FATHER

What is your father's name? _____

Is he alive? ___ YES ___ NO If deceased, what was the cause of death? _____

Father's occupation: _____

Father's level of education: _____

Father's hobbies: _____

Does you father have a known or suspected learning disability? ___ YES ___ NO

If yes, please describe: _____

Briefly describe your father's health history: _____

_____

How many siblings (brothers and sisters) do you have? ____

Where are you in the birth order? ____

Are there any unusual problems (physical, academic, psychological) associated with any of your siblings? ___ YES ___ NO
If yes, please describe: _____

_____

Who raised you?

____ Biological Parent(s) ____ Relatives ____ Foster Parents
____ Biological Parent plus other person ____ Adoptive Parents ____ Institutional Setting
____ Others Who? _____

What languages were spoken at home when you were a child? _____

_____

Please check all that exist(ed) in close biological family members (parents, siblings, grandparents, aunts, uncles), note who it is/was, and describe the problem.

	Who?	
_____ Epilepsy or seizures	_____	_____
_____ Learning disability	_____	_____
_____ Left-handedness	_____	_____
_____ Intellectual Disability	_____	_____
_____ Speech or language disorder	_____	_____
Neurologic (brain) disease		
_____ Alzheimer's disease	_____	_____
_____ Senility	_____	_____
_____ Huntington's disease	_____	_____
_____ Multiple sclerosis	_____	_____
_____ Parkinson's disease	_____	_____
_____ Other neurologic disease	_____	_____
Psychiatric illness		
_____ Alcoholism	_____	_____
_____ Bipolar illness (manic-depression)	_____	_____
_____ Depression	_____	_____
_____ Personality disorder	_____	_____
_____ Schizophrenia	_____	_____
_____ Other psychiatric illness	_____	_____
_____ Other major disease or disorder	_____	_____

PERSONAL HISTORY

MARITAL HISTORY

Current marital status: ___ Married ___ Single ___ Divorced ___Widowed ___ Separated

Years married to current spouse: ____

Number of times married: ____

Spouse's name: _____ Spouse's age: ____

Spouse's occupation: _____

Spouse's health: ___ Excellent ___ Good ___ Poor

Not married but living with someone: ___ YES ___ NO His/Her age: ____

His/Her health: ___ Excellent ___ Good ___ Poor

EDUCATIONAL HISTORY

Highest grade or degree earned: _____

How would you describe your usual performance as a student?

___ **A & B** ___ **B & C** ___ **C & D** ___ **D & F**

Please provide any additional information that may be helpful about your academic performance: _____

_____

_____

What was your best subject(s)? _____ Weakest subject(s)?_____

Were you ever held back to repeat a grade? ___ YES ___ NO

If yes, what grade(s)? _____ Reason? _____

Were you ever in any special class(es) or received any special services? ___ YES ___ NO

If yes, what grade(s)? _____ Or age? _____ What type of class? _____

OCCUPATIONAL HISTORY

Current job title: _____

Salary: ___ Under $10,000 ___$10,000-29,999 ___$30,000-50,000 ___ Over $50,000

How long have you been at this job? _____

Current job responsibilities: _____

Prior jobs (Start with most recent) : Time on this job:

_____ _____

_____ _____

_____ _____

At any time on a job, were you exposed to toxic, hazardous, noxious, or otherwise dangerous or unusual substances (e.g. lead, mercury, radiation, solvents, pesticides, chemicals, etc.)?
___ YES ___ NO

If yes, please explain: _____

MILITARY HISTORY

Branch: _____

Discharge rank: _____ Type of discharge: _____

Major military duties: _____

Did you sustain any physical injuries in the military? ___ YES ___NO

If yes, please describe: _____

Were you ever exposed to any dangerous or unusual substances during your service (e.g.

Agent Orange, radiation, etc.)? ___ YES ___ NO

If yes, please explain: _____

RECREATION

Briefly list the types of recreation (sports, games, TV, hobbies, etc.) that you enjoy: _____

_____

SUBSTANCE USE HISTORY

ALCOHOL

I started drinking regularly at age:

___ less than 10 years old ___ 10-15 ___ 16-18 ___ 19-21 ___ over 21

I drink alcohol: ___ rarely or never ___ 1-2 days/week ___ 3-5 days/week ___ daily

I used to drink but have stopped: _____ Date stopped: _____

Preferred type(s) of drinks: _____

Usual number of drinks I have at a time: _____

My last drink was: ___ less than 24 hours ago ___ 24-48 hours ago ___ over 48 hours ago

Check all that apply:

___ I can drink more than most people my age and size before I get drunk.

___ I sometimes get into trouble (fights, legal difficulty, problems at work, conflicts with family, accidents, etc.) after drinking.

___ I sometimes blackout after drinking.

DRUGS

Please check all the drugs you are now using or have used in the past:

	Presently using	**Used in past**
Amphetamines (inc. diet pills)	_____	_____
Barbiturates (downers, etc.)	_____	_____
Cocaine or Crack	_____	_____
Hallucinogenics (LSD, acid, STP, etc.)	_____	_____
Inhalants (glue, nitrous oxide, etc.)	_____	_____
Marijuana	_____	_____
Opiate narcotics (heroin, morphine, etc.)	_____	_____
PCP (or “angel dust”)	_____	_____

Please list all other drugs:

_____

Do you consider yourself a dependent on any drug? ___ YES ___ NO

If so, what drug(s)? _____

MEDICAL TESTING

Check all the medical tests that have been done and report any abnormal findings:

		Abnormal Findings
_____	Angiography	_____
_____	Blood work	_____
_____	Brain scan	_____
_____	CT scan	_____
_____	EEG	_____
_____	Lumbar puncture or spinal tap	_____
_____	Magnetic Resonance Imaging (MRI)	_____
_____	Neurological office exam	_____
_____	PET scan	_____
_____	Physicians office exam	_____
_____	Skull e-ray	_____
_____	Ultrasound	_____
_____	Other testing	_____

Identify the physician who is most familiar with your recent problems:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Date of your last medical check-up: _____

Findings of the check-up: _____

Have you had prior psychological or neuropsychological evaluation? ___ YES ___ NO

If yes, please complete this information:

Name of psychologist: _____

Address: _____

_____

Phone: _____ Fax: _____

Date of and reason for this evaluation: _____

Findings of the evaluation: _____

Please provide NeuroBehavioral Associates with the final report for this evaluation.

THIS FORM HAS BEEN COMPLETED BY: ____ Patient ____ Other
If not completed by the patient, please provide the following information.

Name: _____ Relationship to patient: _____

Address: _____

_____

Phone (H): _____ (W) _____

Thank you for taking the time to carefully complete this questionnaire.