SERENITY NEUROPSYCHOLOGY, PLLC

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Please **circle YES or NO** as relevant. Otherwise, answer the specific questions asked. Thank you.

******PLEASE be complete. This form will help provide a thorough history necessary for treatment.**

Patient Name:_____________________________________ DOB:_________________
Name of person completing this form if other than the patient____________________________________
Relationship to the patient________________________________

Do you prefer to be called by a nickname?______________________________

What are your treatment goals?____

Describe any significant stressors you have experienced during the PAST 1-2 YEARS
____
____

Developmental/Childhood History

What is your primary language?_____________________________
Were you adopted? Yes No
If yes, how old were you when you were adopted?_________
To your knowledge, did you meet developmental milestones on time (walking,talking)? Yes No
Were you born prematurely? Yes No
If yes, how many weeks premature?___________
To your knowledge, were there any complications during your mother's pregnancy with you or during your birth? Yes No
If yes, what were the complications?____
Did you experience any type of abuse as a child? Yes No
If yes, what type of abuse____
Are/were your parents divorced? Yes No
If yes, how old were you when they divorced? age______
Number of biological brothers____ biological sisters____ half-brothers____ half-sisters____
stepbrothers____ stepsisters____ adopted brothers____ adopted sisters____
Where were you born?_______________________Where were you raised?____________________________
Who lived in your home with you during your childhood?____
____
Please describe any significant events in your childhood?____
____
What is your sexual orientation?____________________________________ **OR** Prefer Not to Answer_______

Health History

Do you have pain or neuropathy in your hands? Yes No Carpal Tunnel Syndrome? Yes No
Surgery on your hands for any condition? Yes No Injury to your hands? Yes No
If yes to any of the above, which hand is impacted: Right_______ Left________ Both_________
Are you color blind? Yes No

Hearing Aids Yes No Which Ear: R___L___Both___ Glasses Yes No
If no hearing aids, do you feel you need hearing aids/are you having trouble hearing others speak? Yes No

Are you currently being subjected to any abuse, neglect, or abandonment? Yes No
In the past 2 weeks, have you felt sad, down, or depressed? Yes No
In the past 2 weeks, have you lost interest or pleasure in activities or people? Yes No
How would you rate your level of depression during the past 2 weeks from 0 (no depression) to 10 (representing suicidal thinking)? ______
Have you been feeling anxious about a number of situations for at least the past 6 months? Yes No
Do you find it hard to stop worrying about situations/things? Yes No
How would you rate your level of anxiety during the past 2 weeks from 0 (no anxiety) to 10 (representing a panic attack)? ______
How many hours of sleep do you get on average?______
Do you have trouble going to sleep? Yes No staying asleep? Yes No waking too early? Yes No

Have **you** noticed any change in your personality/behaviors recently? Yes No
If yes, please describe____
Has anyone told you that your personality/behaviors seem different, inappropriate, or unusual compared to how you once acted? Yes No
If yes, please describe____

Have you ever been hospitalized for a psychiatric/mental health disorder? Yes No
If yes, length of time___________When___________________Reason _________________________
Have you ever engaged in outpatient counseling? Yes No
If yes, length of time___________When_________________Reason____________________________
Are you currently in outpatient counseling? Yes No With Whom__________________________________
If not in counseling, are you interested in doing outpatient counseling/individual therapy? Yes No

Have you **in the past or are you currently experiencing** any of the following?
Delusions Yes No
Cutting Behaviors Yes No
Current Thoughts of Killing Yourself Yes No
Past Suicidal Attempts Yes No
Hallucinations Yes No
Thoughts of Harming Someone Else Yes No
Past Thoughts of Killing Yourself Yes No
Anger Management Problems Yes No
If you experience suicidal thoughts, describe how you keep yourself safe?_____________________________
____

Do you have any of the following concerns?
Poor Balance/Falling Yes No
Tingling in Arms/Legs Yes No
Short-Term Memory Loss Yes No
Misplacing or Losing Objects Yes No
Remembering To Turn Off the Oven/Burner Yes No
Remembering Conversations Yes No
Increased Driving Accidents or Tickets Yes No
Getting Lost in a Store/Mall Yes No
Difficulty Finding the Correct Word Yes No
Object Naming Problems Yes No
Thinking Slower/Reduced Processing Speed Yes No
Dizziness Yes No
Increased Confusion Yes No
Long-Term Memory Loss Yes No
Going Into a Room and Forgetting Why Yes No
Remembering to Attend Appointments Yes No
Remembering the Rules of Driving Yes No
Getting Lost While Driving Yes No
Problem-Solving Difficulty Yes No
Difficulty Understanding Words Yes No
Difficulty Doing 2 Things at Once Yes No
Decreased Focus/Attention Yes No

Have you ever had a Brain MRI? Yes No Brain CT? Yes No Brain PET? Yes No
Any other neurological tests? Yes No Which tests______________________________________
Sleep study? Yes No When____
Recent blood word/labs performed? Yes No Where____

Do you see a neurologist? Yes No If yes, Provider or Clinic______________________________________

Please review the following conditions and **circle YES or NO. <u>Only endorse yes if you have been formally diagnosed and/or you are receiving formal treatment for the condition</u>. Please make a separate notation on the line provided below if you feel you have a condition but you have never been formally diagnosed**.**

Addison's Disease Yes No
ALS/Lou Gehrig's Disease Yes No
Anemia Yes No
Aneurysm Yes No
Anoxia Yes No
Anxiety Yes No
Arthritis Yes No (Type___________________________)
Asthma Yes No
Atrial Fibrillation Yes No
Attention-Deficit/Hyperactivity Disorder Yes No
Autism or Asperger's/Autism Spectrum Disorder Yes No
Auto Immune Yes No (Type______________________)
Bipolar Yes No
Borderline Personality Disorder Yes No
Brain Arteriovenous Malformation (AVM) Yes No
Brain Tumors Yes No
Carbon Monoxide Poisoning Yes No
Cerebral Palsy Yes No
Cerebral Vascular Accident (Stroke) Yes No
Cerebral Vasculitis Yes No
Chronic Fatigue Syndrome Yes No
COPD Yes No
COVID-19 Yes No
Cushing's Disease Yes No
Dementia Yes No (Type_________________________)
Depression Yes No
Diabetes Type 1 Yes No
Diabetes Type 2 Yes No
Eating Disorder Yes No (Type_____________________)
Electrical Shock Injury Yes No
Encephalitis Yes No
Epilepsy/Seizures Yes No (Type___________________)
Fibromyalgia Yes No
Gum Disease Yes No
Hashimoto's Yes No
Head Injury or Concussion Yes No
Heart Attack Yes No
Hepatitis C Yes No
High Blood Pressure/Hypertension Yes No
High Cholesterol Yes No
HIV/AIDS Yes No
Hoarding Yes No
Hormonal Changes Yes No
Hydrocephalus Yes No
Hyperparathyroidism Yes No
Hyperthyroidism Yes No
Hypothyroidism Yes No
Huntington's Disease Yes No
Incontinence Yes No
Insomnia Yes No
Kidney Disease Yes No (Stage_______)
Learning Disability Yes No
Long-COVID Yes No
Lupus Yes No
Lyme Disease or Chronic Lyme Yes No
Meningitis Yes No
Metabolic Conditions Yes No
Migraine Headaches Yes No
Mild Cognitive Impairment Yes No
Multiple Sclerosis Yes No
Nonepileptic Seizures Yes No
Obesity Yes No
Obsessive Compulsive Disorder Yes No
Parkinson's Yes No
Post Traumatic Stress Disorder Yes No
REM Behavior Sleep Disorder Yes No
Restless Legs Syndrome Yes No
Schizophrenia Yes No
Sjogren's Yes No
Substance Abuse Yes No
Tension Headaches Yes No
Toxic Exposure Yes No
Transient Ischemic Attack/TIA Yes No
Tremors Yes No (Type______________)
Urinary Infections (Frequent)/UTI Yes No
Vit B12 deficiency Yes No
Vit D deficiency Yes No
Whiplash Yes No
Cancer Yes No (Type____)
Did you have chemotherapy Yes No Radiation Yes No Other Treatment Yes No
Chronic Pain Yes No Please rate your <u>typical</u> pain from 0-10 with 10 meaning worst imaginable pain______
Sleep Apnea Yes No (CPAP Yes No BIPAP Yes No Oral Appliance Yes No Inspire Implant Yes No)

Other Conditions <u>Formally Diagnosed</u>:____
**Conditions in which you feel you experience but are not diagnosed________________________________
____
How many times have you had surgery in which you were placed under general anesthesia____
Have you had heart surgery? Yes No Have you had brain surgery? Yes No

Please list all medications, including supplements and over-the-counter

Check Here_________ if you prefer to attach a list instead of listing them below:

Type of Medication **Dosage/Frequency** **Purpose**

1.____

2.____

3.____

4.____

5.____

6.____

Others medications/supplements______________________________

Date you most recently saw your prescribing provider for **PSYCHIATRIC MEDICATION ONLY**?____________

Who do you see for **PSYCHIATRIC MEDICATION ONLY?**______________________

Substance Abuse History

Do you **CURRENTLY** drink alcohol? Yes No

If yes... How often?______________________

How much do you drink in one sitting?______________________

How long have you been drinking?______________________

Type of alcohol?______________________

Have you **ABUSED** alcohol in the past OR have you OR someone else ever been concerned about your drinking? Yes No

If yes, when did you stop abusing alcohol (age/year)?____________________

Do you **CURRENTLY** use recreational drugs? Yes No

If yes... How often do you use drugs?______________________

What types of drugs do you use?______________________

How long have you been using drugs?______________________

When was your last use and what drug did you use?______________________

Have you used recreational drugs in the past? Yes No

If yes... What drugs have you used?______________________

When did you stop using (age/year)?______________________

Have you attended chemical dependency treatment for alcohol and/or drug use? Yes No

If yes, when?___________________ How long was treatment?_____________________

Do you **CURRENTLY** use nicotine? Yes No

If yes, how long have you used nicotine?________ How much do you use?________________________

Have you used nicotine in the past? Yes No

If yes, how long did you use?_______ How much did you use?______________________

What type of nicotine did you use?_________________________ When did you quit (age/year)?__________

Do you currently vape substances? Type___________________________________ Yes No

Did you vape substance(s) in the past? Type_________________________________ Yes No

Legal History

Have you ever been convicted of any crimes other than minor traffic violations? Yes No

If yes, please explain____

Are you **currently** involved in any legal issues (someone is suing you, you are suing someone, you anticipate upcoming legal problems) Yes No

If yes, please explain____

Please **circle YES or NO** regarding whether you have **difficulty doing the following activities independently with no assistance from others?**

Dressing Yes No
Feeding Yourself Yes No
Housekeeping Yes No
Using the Telephone Yes No
Using the Oven/Stove Yes No
Using Public Transportation Yes No
Remembering to Take Medications Yes No
Communicating Yes No
Remembering Your Bills Yes No
Laundry Yes No
Following Unfamiliar Recipe Yes No
Toileting Yes No
Bathing Yes No
Shopping/Remembering Grocery Items Yes No
Using the Remote Control Yes No
Using the Microwave Yes No
Driving Yes No
Organizing or Ordering Medications Yes No
Socializing Yes No
Writing Out Checks Yes No
Cooking/Preparing Meals Yes No
Remembering and/or Following Familiar Recipe Yes No
Other Difficulties in Daily Life (please described)____

Do you have power of attorney papers completed? Yes No
Do you have a living will or advanced directives completed? Yes No

Educational History
Education: Less than High School___ High School___ Some college___ AA___ BS/BA___ MS/MA___ Doctorate____ If Less than High School, have you earned your GED? Yes No

If you attended college, what was your major(s)?____
If you attended graduate/medical/law school, what was your emphasis/major?__________________________

What grades did you make in:
Elementary School: A B C D F
High School: A B C D F Final GPA______
College/Undergraduate: A B C D F Final GPA______
Graduate/Medical/Law School: A B C D F Final GPA______

Have you you ever been diagnosed with a learning disability? Yes No
If yes, what type(s)?____
Did you receive accommodations/special education in school? Yes No
Did you need to repeat a grade(s)? Yes No
If yes, what grade or grades?_______ Reason for repeat?_____________________________
Behavioral problems in school (Principal's office, skipped school, expelled, suspended)? Yes No

What was your favorite subject(s) in school?____
What was your least favorite subject(s) in school?____

What was the name of your College/Undergraduate School?_____________________________________
What was the name of your Graduate/Medical/Law School?_____________________________________

Occupational History
Are you currently working? Yes No
If yes, how long have you been working at your current position?___________
If no, what is the reason you are not working? Retired____ Disability____ Other______________________
What is/was your occupation?____
Types of previous jobs____
Longest amount of time you held a job and what was your position?______________________________

Do you have a volunteer position? Yes No
If yes, how long have you been volunteering?_______ Where?_____________________________________
If yes, what are your duties/position?____

Military History
Have you ever served in the military? Yes No What branch?________________________________
Did you see active combat? Yes No How long did you serve?____________Number of tours?_________
What were your duties/position/rank?____

Psychosocial History
In what city do you live?___________________With whom do you live?______________________________
If relevant, Spouse's/Partner's Name_____________________Spouse's Occupation______________________
How long have you been with your spouse/partner?__________ Times you have you been married?______
Do you have children? Yes No
What are their names and ages?____
Do you have any pets? Yes No
What types of pets and their names?____
How often do you exercise? Never/Rarely___ 1-2x per week___ 3-4x per week___ 5-7x per week___
Type of exercise? ____
Activities/hobbies?____
Level of social support? Poor___ Fair___ Average___ Above Average___
Who do you look toward for social support?____
Do you have a religious preference?____
What are your strengths?____
What are your weaknesses?____

Family History (**include only your BIOLOGICAL children, parents, siblings, grandparents, aunts/uncles**)
Has anyone in your **above included** family members been **formally diagnosed** with the following?

			Relationship
1) Depression	1. Yes	No	________________________
2) Bipolar	2. Yes	No	________________________
3) Schizophrenia	3. Yes	No	________________________
4) Anxiety	4. Yes	No	________________________
5) Post Traumatic Stress Disorder	5. Yes	No	________________________
6) Obessive Compulsive Disorder	6. Yes	No	________________________
7) Alcohol Abuse	7. Yes	No	________________________
8) Drug Abuse	8. Yes	No	________________________
9) ADD/ADHD	9. Yes	No	________________________
10) Dementia (Type___________________________)	10. Yes	No	________________________
11) Mild Cognitive Impairment	11. Yes	No	________________________
12) Multiple Sclerosis (MS)	12. Yes	No	________________________
13) Parkinson's Disease	13. Yes	No	________________________
14) Stroke/TIA's (transient ischemic attack)	14. Yes	No	________________________
15) ALS/Lou Gehrig's Disease	15. Yes	No	________________________
16) Epilepsy/Seizure Disorder	16. Yes	No	________________________
17) Auto Immune (Type________________________)	17. Yes	No	________________________
18) Diabetes	18. Yes	No	________________________
19) Cancer	19. Yes	No	________________________
20) High Blood Pressure	20. Yes	No	________________________
21) High Cholesterol	21. Yes	No	________________________
22) Heart Disease	22. Yes	No	________________________

23) Other____

Is your father living? Yes No Age of death?________ Cause of death______________________________
Is your mother living? Yes No Age of death?________ Cause of death______________________________
Was anyone in your **biological** family deceased prior to age 65? Yes No Unknown
If yes, relationship to you and cause of death____