HAMPTON ROADS NEUROPSYCHOLOGY, INC
PATIENT HISTORY FORM

Demographics:
Name:_____
Age:_____ Date of Birth:_____
Handedness: (Choose one) ◯Right ◯Left ◯Ambidextrous
Marital status:_____
Highest level of education:_____
Occupation:_____

Instructions: Click on each line to type in your answer, or click on a button to make your selection. When completed, please Save and e-mail this form to:

hrnadmin@thememoryclinic.com

Thank You

Medical History:
Who referred you for this evaluation?_____
Other healthcare providers?

_____
_____
Reason for this referral?

_____
_____
What would you like to gain from this evaluation?

_____
_____
Do you have any medical conditions? No, or if Yes please list:

_____
_____
Do you have any neurological conditions? No, or if Yes please list:

_____
_____
Do you have any psychiatric conditions? No, or if Yes please list:

_____
_____

Social History (please answer mostly yes or mostly no):

Do you exercise on a regular basis?	◯Yes	◯No
Do you eat a balanced nutritional diet?	◯Yes	◯No
Do you have any problems with your sleep?	◯Yes	◯No
Do you have any pain complaints?	◯Yes	◯No
Do you engage in mentally stimulating activities?	◯Yes	◯No
Do you drink alcohol?	◯Yes	◯No
Do you use tobacco?.	◯Yes	◯No
Do you have concerns about over use of drugs, street or prescription?	◯Yes	◯No
Do you have any problems with spouse or family members?	◯Yes	◯No
Do you have any problems with your place of residence?	◯Yes	◯No
Do you have any financial stressors?	◯Yes	◯No

Functional Ability (please answer mostly yes or mostly no):

Do you need any assistance in shopping?	◯Yes	◯No
Do you need any assistance in meal preparation?	◯Yes	◯No
Do you need any assistance in housekeeping?	◯Yes	◯No
Do you need any assistance in doing laundry?	◯Yes	◯No
Do you have any concerns about your driving?	◯Yes	◯No
Do you need assistance in taking your medications?	◯Yes	◯No
Do you need assistance in managing your finances?	◯Yes	◯No
Do you have concerns about your decision making in meeting daily demands?	◯Yes	◯No

Emotional Adjustment (please answer mostly yes or mostly no):

Are you basically satisfied with your life?	Yes	No
Have you dropped many of your interests and activities?	Yes	No
Do you feel that your life is empty?	Yes	No
Do you often get bored now?	Yes	No
Are you in good spirits most of the time?	Yes	No
Are you afraid of something bad is going to happen to you now?	Yes	No
Do you feel happy most of the time now?	Yes	No
Do you often feel helpless now?	Yes	No
Do you prefer to stay at home rather than to go out now?	Yes	No
Do you feel that you have more problems with memory than most people do?	Yes	No
Do you think it is wonderful to be alive now?	Yes	No
Do you feel pretty worthless the way you are now?	Yes	No
Do you feel full of energy now?	Yes	No
Do you think that your situation is hopeless now?	Yes	No
Do you think that most people are better off than you now?	Yes	No

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Do you have numbness or tingling sensation in your body?	Yes	No
Do you feel hot but not because of the temperature?	Yes	No
Do you have wobbliness in your legs?	Yes	No
Are you unable to relax?	Yes	No
Do you fear that the worst is going to happen to you?	Yes	No
Do you feel dizzy or lightheaded?	Yes	No
Do you feel that your heart is pounding or racing?	Yes	No
Do you feel unsteady on your feet?	Yes	No
Do you feel terrified?	Yes	No
Do you feel nervous?	Yes	No
Do you feel as if you are choking?	Yes	No
Do your hands tremble?	Yes	No
Do you feel shaky all over?	Yes	No
Do you have a fear of losing control?	Yes	No
Do you have difficulties breathing?	Yes	No
Do you have a fear of dying?	Yes	No
Do you feel scared?	Yes	No
Do you have indigestion or discomfort in your abdomen?	Yes	No
Do you feel as though you will faint?	Yes	No
Do you feel as though your face is flushed?	Yes	No
Do you feel that you are sweating but not from the heat?	Yes	No

Please list medications:

_____

_____

_____

Any additional concerns?

_____

_____

_____

_____

_____

_____

_____