NBS-JAX Neuropsychology History Form: FAA

NAME:____ **DATE OF BIRTH:**_____/____/_______ **AGE:**_____

ADDRESS:____ **PHONE #:**______________________________

HANDEDNESS: Right / Left / Both **Referred By:** _________________________

Please answer each item to the best of your knowledge. Use the back of any page to add more information.

WHY WERE YOU REFERRED FOR A NEUROPSYCHOLOGICAL EVALUATION? WHAT IS THE REASON FOR THIS EVALUATION?

PRESENT CONCERNS: DESCRIBE THE TYPES OF PROBLEMS YOU ARE HAVING. For example, What are the problems? When did they start? How bad are they? Are they getting better or worse? How do they affect you?

CURRENT SYMPTOMS: Check any of the following if they are a *current* problem for you.

Sensory: ☐Numbness/Loss of Sensation ☐Tingling/Burning ☐Pain or Temperature Sensitivity ☐Change in Taste/Smell

☐Hearing Loss ☐Bad Tastes/Smells ☐Ringing Ears

Motor: ☐Decreased Coordination ☐Weakness ☐Paralysis ☐Spasms/Tremors ☐Chewing/Swallowing Problems

COGNITIVE SYMPTOMS:

Consciousness: ☐Fainting or Blackout ☐Losing Sense of Time ☐Dizziness ☐Confusion ☐Poor Concentration ☐Distractibility

Memory: ☐Problems Remembering New Things (names, faces, phone numbers, etc.) ☐Difficulty Remembering the Past

Speech: ☐Difficulty Expressing Thoughts ☐Difficulty Understanding Others ☐Change in Articulation or Slurring Speech

☐Using Wrong Words ☐Trouble Finding the Right Word ☐Stumbling Over Words

Thought Processes: ☐Trouble Organizing Thoughts ☐Difficulty Solving Problems ☐Changes in Reading/Writing/Spelling Skills ☐Changes in Math Skills ☐Slowed Thinking

OTHER SYMPTOMS:

☐Crying ☐Sadness ☐Appetite Change ☐Loss of Pleasure ☐Stress ☐Hyperactive ☐Temper Outbursts
☐Irritability ☐Impulsive ☐Fears ☐Social Isolation ☐Substance Use ☐Change in Motivation
☐Anxiety/Tension/Nervousness ☐Sleep problems ☐Pain ☐ Headaches ☐ Suicidality

NBS-JAX Neuropsychology History Form: FAA

CHILDHOOD & DEVELOPMENTAL HISTORY:

Where were you born/raised?______________________ **Who raised you?**________________

Primary Language(s):________________________**Number of Siblings:**__________ **Birth Order:** __________

DID YOU MOTHER HAVE PREGNANCY COMPLICATIONS?:
☐Mother took alcohol or drugs while pregnant ☐Mother smoked while pregnant ☐Mother was ill while pregnant ☐Toxemia ☐Threatened Miscarriage ☐Excessive Vomiting
☐Other (Specify):____

COMPICATIONS WHEN YOU WERE BORN:
☐Low Birth Weight ☐Premature ☐Oxygen Deprivation ☐Injury at Delivery ☐Cord Around Neck ☐Breech Delivery ☐Bleeding ☐Jaundice ☐Turned Blue ☐Deformity (Specify)______________________
☐Illness at Birth (Specify) _______________________________________

OTHER CHILDHOOD PROBLEMS:
☐Eating/Feeding ☐Sleeping ☐Colic ☐ Crawling ☐Standing ☐Walking ☐Throwing ☐Writing
☐Spelling ☐Talking ☐Clumsiness ☐Bedwetting ☐Potty Training ☐Behavior Problems
☐Other (Specify)____

CHILDHOOD ILLNESSES/SURGERIES:
☐Loss of Consciousness ☐Concussion ☐Tonsillectomy ☐Convulsions ☐Seizures ☐Tics ☐Repeated Ear Infections ☐Encephalitis ☐Meningitis ☐Cancer ☐High Fever (over 104) ☐Pneumonia ☐Allergies ☐ Asthma/Bronchitis ☐Accidental Poisoning ☐Oxygen Deprivation/Near Drowning ☐Cerebral Palsy ☐Multiple Sclerosis ☐Long Hospital Stay ☐Operations ☐Other:
____

EDUCATION & OCCUPATIONAL HISTORY:

EDUCATIONAL HISTORY: Highest Grade Completed: _______________

University/Professional Degree Major: ________________

Grades/GPA in *High School*:____________**Grades/GPA in *College/Professional School*:**______________

☐**Special Education, Accommodations, or Tutor (specify):**____

☐**School Problems:** ☐Reading ☐Spelling ☐Math ☐Getting into Trouble ☐Keeping Attention

☐Held Back ☐Dropped Out

Best Subject(s) ____

Worst Subject(s) ____

SAT/ACT Score(s): _____________________

NBS-JAX Neuropsychology History Form: FAA

EMPLOYMENT STATUS: ☐Unemployed ☐Full-Time ☐Part-Time

Employer Name	Approximate Dates	Reason(s) for Leaving
1.		
2.		
3.		
4.		
5.		

CURRENT/PAST PROBLEMS AT WORK (Written-Up, Oral Counselings, Conflicts, Complaints about You, Etc-
____

EVER FIRED OR SUSPENDED FROM WORK? YES / NO If yes, why?____________________

☐**Disabled:** Since When? __________ Why? ____________________

☐**Retired:** Since When? ____________

SOURCES OF INCOME: ________________________________

☐**Military Service:** Military Branch:_____________ Service Dates: ___________Highest Rank: ___________

Military Occupation:______________ ☐ Article 15s, Office Hrs, Other Discharge Type: ________________

☐**Combat Exposure:** If yes, where? _______________ Dates: __________

LEGAL HISTORY:

☐**Juvenile Problems** (truancy, school suspensions, etc.)
(Specify)____

☐**Misdemeanors, Felonies, or Civil Litigation and/or Arrest**
(Specify)____

☐***Ever*** **Involved in Litigation, Disability Application, or Worker's Compensation**
(Specify)____

MEDICAL HISTORY:

Please check any of the following that you have ever had:

☐Tuberculosis	☐Vitamin Deficiency	☐Chronic Pain	☐Meningitis	☐Pain
☐Rheumatic Fever	☐Hepatitis (A/B/C)	☐Chronic Fatigue	☐Encephalitis	☐Toxic/Chem. Exposure
☐Scarlet Fever	☐HIV+	☐Fibromyalgia	☐Delirium	☐Dementia/ Senile
☐Whooping Cough	☐STD	☐Asthma	☐Coma	☐Depression
☐Chicken Pox	☐Autoimmune Dx	☐COPD	☐Hypoglycemia	☐Anxiety
☐Polio	☐Thyroid Problems	☐Blood Disease	☐Diabetes	☐Panic
☐Measles/Mumps	☐Kidney Disease	☐Insomnia	☐Stroke	☐ADHD
☐Cerebral Palsy	☐Liver Disease	☐Sleep Probs.	☐Sleep Apnea	☐Bipolar
☐Cystic Fibrosis	☐Lung Disease	☐Menopause	☐Vascular Dx	☐Substance Abuse

NBS-JAX Neuropsychology History Form: FAA

☐Learning Problem ☐Mental Retardation ☐Multiple Sclerosis ☐Cerebral Aneurysm ☐Headaches ☐Ear Infections ☐Heart Attack ☐Heart Disease ☐Suicide Attempt ☐Traumatic Experiences

☐Pneumonia ☐High Fever ☐Infections ☐Oxygen Deprivation ☐Muscle Disease ☐Movement D/O ☐Neurologic D/O ☐Urinary Tract Infection ☐Migraines ☐Brain Injury ☐Seizures ☐Other: ________________ ☐Heart Failure ☐Hypertension ☐Pneumonia ☐Psychosis ☐Cancer/Tumor ☐Anemia

When was the last time you received a physical examination from a doctor? ________________

Anyone in your family had or have one or more of the conditions listed above? If yes, please specify:

____

List Your Current Medications- Prescribed, Over-The-Counter, and Supplements (please use the other side if you need more room)**:**

Medication Name	Condition Used For	Dose	Times per Day	Side Effects
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Tests You Have Had: ☐Head Angiogram ☐CT ☐MRI ☐fMRA ☐ MRA ☐PET ☐SPECT ☐EEG ☐Spinal Tap ☐Sleep Study

Treatments You Have Had: ☐Blood Transfusion ☐Chemotherapy ☐Radiation ☐Brain Surgery ☐Spine Surgery ☐Organ Transplant ☐Major Surgery ☐Major Hospitalization ☐Psychiatric Hospitalization ☐Rehabilitation ☐Psychiatrist ☐Counselor ☐Psychologist ☐Speech Therapist ☐Neurologist ☐ Neuropsychologist ☐ Chiropractor

SUBSTANCE USE HISTORY:

Check Any Substances That You Have Ever Used:

☐ Alcohol **Age Started:** ______ **Age Quit:** ______ **How many drinks do, or did, you have per week?** _______

☐ Tobacco **Age Started:** ______ **Age Quit:** ______ **How much do, or did, you smoke/chew per day?** _______

NBS-JAX Neuropsychology History Form: FAA

☐ **Other Recreational Drugs (check where applicable):** ☐Marijuana ☐Cocaine ☐Methamphetamine
☐Heroin ☐Sniffed Fumes ☐LSD ☐PCP/Angel Dust
☐Prescription Drugs (specify)____________________________ ☐Other (Specify)________________________________

☐ **Participated in Treatment for Alcohol, Tobacco, and/or Drug Use**.
Specify:____

Ever been told you have an alcohol problem? Yes / No If yes, elaborate: _____________________________________

Have you ever been charged with a DUI/DWI or for public intoxication? Yes / No If yes, elaborate: _____________

____

Anyone in your family have or had problems with abusing substances? If yes, please specify:

____

____

CURRENT SITUATION:

MARITAL STATUS: Married / Separated / Divorced / Widowed / Partnered / Single
Length of Time Married: __________ **Times Married:** ______
Length of Time in Committed Partnership: ____________

Number, Sex, & Age of Biological & non-Biological Children: ____

Whom (and age) do you live with? ____

FAA PILOTS: Aviation History

What flight school did you attend? ________________________________ When____________________

When did you receive your private pilot's license? ______________________________________

How many flight hours have you accrued? ____

***I have answered all of the above information honestly and openly to the best of my ability.**

Signature: _________________________________

Full Name: ________________________________

Date Form Completed: __________________