New Peaks
NEUROPSYCHOLOGY

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ADULT BACKGROUND HISTORY FORM

This questionnaire deals with the following: Prenatal development, medical history, performance in school, & family history. Please provide as much detail as possible. If you have additional information, such as school transcripts, medical records, or previous assessments, please bring these along. All this information will be reviewed with you in detail, but it is helpful to have a complete & accurate record before we meet. Thank you!

Today's Date:_____ **Name of Individual Completing Form:** _____
(*If not patient)*
Relationship to patient: _____

Patient's Demographic Information:

Name:	
Sex Assigned at Birth:	
Preferred Pronouns:	
Age:	
Birthdate:	

Please check the relationship status that best suites you:

☐ Not Dating	☐ Casual Dating	☑ Serious/Engaged/Living with a Significant Other	☐ Married	☐ Divorced (indicate number of previous marriages)

If your parents are separated or divorced, please specify date and/or your age at that time:

_____

_____

_____

EVALUATION OBJECTIVES: CURRENT NEEDS

What are your goals & expectations for this evaluation? What do you want to discover?

1)

2)

3)

What are your strengths?

1)

2)

3)

Please list your current difficulties. Include when you first became concerned and what you think may be the cause of the problem.

1)

2)

3)

FAMILY HISTORY

Please list all the people living in your **Current Home**:

Name	Age	Relationship to You

Please list all the people living in your **Childhood Home**:

Name	Age	Relationship to You

Please provide information about your parents and/or primary caregivers.

	Age	Level of Education	Occupation	Please describe any learning or attention difficulties
Parent 1				
Parent 2				
Other Parent/Caregiver				
Other Parent/Caregiver				

Please check for each sibling: Full or half-sibling, or not biologically related.

Sibling Name	Age	Level of Education	Full	Half	Not Bio Related	Please describe any learning or attention difficulties
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	

Please list your children's names and ages if applicable:

MEDICAL HISTORY

Please list and describe any medical conditions that run in the family (including but not limited to thyroid disease, diabetes, elevated blood pressure, heart problems, and cancer). See the following table for learning and psychological/psychiatric conditions.

Does any relative have:	Yes	No	Relationship (Specify blood relation ornot)	Description of Issue
Learning Problems (Be specific)	☐	☐		
ADHD	☐	☐		
Tourette's Syndrome or Tics	☐	☐		
Autism Spectrum Disorder or Asperger's Syndrome	☐	☐		
Anxiety or Panic	☐	☐		
Obsessions/Compulsions	☐	☐		
Depression	☐	☐		
Bipolar Disorder	☐	☐		
Suicidal or Self-Injurious Behavior	☐	☐		
Schizophrenia	☐	☐		
Impulsive, Risk-Taking Behavior	☐	☐		
History of Victimization or Trauma	☐	☐		
Drug or Alcohol Abuse (Be Specific)	☐	☐		
Psychiatric Hospitalization	☐	☐		
Other emotional difficulties	☐	☐		
Genetic Disorder	☐	☐		
Neurological Condition (e.g., Seizures, Stroke, Brain Tumor)	☐	☐		
Other:	☐	☐		

OBSTETRICAL HISTORY: PREGNANCY & BIRTH

If you can, please discuss these questions with an individual who has records of pregnancy.

Please answer the following:

Were you adopted? *If yes, at what age and from where?*	
Was it difficult to become pregnant and/or was medical intervention required? *If yes, please specify if possible.*	
Did your mother see a doctor for prenatal care? *If yes, please indicate month care began.*	
How many times was your mother pregnant prior to this pregnancy?	
Did she ever have any miscarriages or abortions? *If yes, please specify if possible.*	
During the pregnancy, how much weight did the mother gain (or lose)?	
Age of mother at delivery	
Age of father at delivery	

Did any of the following occur?	**Yes**	**No**	**If yes, please explain**
Amniocentesis	☐	☐	
Bleeding or Spotting	☐	☐	
Placental Abruption	☐	☐	
Kidney Trouble	☐	☐	
High Blood Pressure	☐	☐	
Swelling of Ankles	☐	☐	
Toxemia or Preeclampsia	☐	☐	
Low Salt Diet	☐	☐	
Water Pill (Diuretics)	☐	☐	
Sugar in Urine/Gestational Diabetes	☐	☐	
Rh Factor	☐	☐	
Mother received Rhogam	☐	☐	
Sickle Cell	☐	☐	
Premature Labor	☐	☐	
Maternal Illness (Rashes, Fevers, Infections)	☐	☐	
X-Rays	☐	☐	
Accident	☐	☐	
Hospital Stay	☐	☐	
Cigarettes/Tobacco (frequency & quantity)	☐	☐	
Alcohol (frequency & quantity)	☐	☐	
Other Maternal Drug/Substance Use	☐	☐	
Emotional/Other Stress	☐	☐	

Please check mark any medications that were used during pregnancy and write any not included under other:

☐ Birth control pills	☐ Prenatal vitamins	☐ Prenatal calcium/iron	☐ Antibiotics
☐ Medicine to keep baby (prevent labor)	☐ Sleeping pills	☐ Tranquilizers	☐ Reducing Pills
☐ Anticonvulsants (for seizures)	☐ Antidepressants	☐ Steroids (prednisone)	☐ Other:

Please answer the following:

How many hours was your mother in labor?	
Apgar Scores (at 1 and 5 minutes)	
Birth weight (pounds, ounces)	
Name of hospital in which you were born	
How many days after delivery did mother and baby leave the hospital?	
Was the pregnancy full-term? *If no, please indicate week of pregnancy child was born.*	
Did your mother go into labor by herself? *If no, was labor induced?*	
Was delivery by Caesarian Section? *If yes, what was the reason for the C-section?*	
Were you born headfirst? *If no, what occurred?*	

Did any of the following complications occur during delivery?	**Yes**	**No**
Forceps or Vacuum extraction used	☐	☐
Premature rupture of membranes (water broke too early)	☐	☐
Doctor had to "turn" the baby	☐	☐
Multiple births (twins, triplets, etc.)	☐	☐
Hemorrhage	☐	☐
High Blood Pressure	☐	☐
Other Complications (Specify):	☐	☐

Did any of the following complications occur after delivery?	**Yes**	**No**
Put in incubator	☐	☐
Blueness	☐	☐
Respiratory Issues (difficulty breathing)	☐	☐
Jaundice (yellow skin)	☐	☐
Convulsions	☐	☐
Did not feed well	☐	☐
Mother had Postpartum Depression	☐	☐
Other difficulties (specify):	☐	☐

Did any of the following difficulties occur as a newborn?	**Yes**	**No**
Colic, excessive irritability, inconsolable crying	☐	☐
Did not sleep very much	☐	☐
Stiff, arched back	☐	☐
Too floppy	☐	☐
Sleepy, lethargic – had to be woken to feed	☐	☐
Feeding problem	☐	☐
Breathing problem	☐	☐
Did not like to be held	☐	☐
Failure to Thrive	☐	☐
Other difficulties (Specify):	☐	☐

DEVELOPMENTAL HISTORY

As best you/your parent/guardians can recall, record the age at which you reached the following developmental milestones. If you cannot recall the age, check the appropriate box to the right.

Milestone	Age	Early	Normal	Late
Sat without support		☐	☐	☐
Crawled		☐	☐	☐
Stood without support		☐	☐	☐
Walked without assistance		☐	☐	☐
Spoke first words (Other than "mama" or "dada")		☐	☐	☐
Said phrases (2-3 words)		☐	☐	☐
Said sentences		☐	☐	☐
Spoke clearly and fluently		☐	☐	☐
Potty trained through the day		☐	☐	☐
Potty trained through the night		☐	☐	☐
Rode a tricycle		☐	☐	☐
Rode a bicycle		☐	☐	☐
Got dressed alone		☐	☐	☐
Buttoned own clothing		☐	☐	☐
Tied shoelaces		☐	☐	☐
Named colors		☐	☐	☐
Named letters and/or numbers		☐	☐	☐

Please answer the following:

Which hand do you prefer to use?	
Have you ever been more active, restless, or fidgety than others? *If yes, when did you first notice this?*	
Have you ever been more impulsive, fearless, or prone to risk-taking compared to peers? *If yes, when did you first notice this?*	
Have you ever been easily distracted and have trouble attending to chores and/or schoolwork? *If yes, when did you first notice this?*	
Were you ever told you were hyperactive or had ADD/ADHD? *If yes, please describe.*	

Currently, how well do you function in the following areas when compared to peers?

Skill	Much worse	Worse	Similar	Better	Far better
Walking	☐	☐	☐	☐	☐
Running	☐	☐	☐	☐	☐
Athletics	☐	☐	☐	☐	☐
Handwriting	☐	☐	☐	☐	☐
Language/Communication	☐	☐	☐	☐	☐
Following directions	☐	☐	☐	☐	☐

SENSORY HISTORY

Have you ever displayed the following behaviors?	Yes	No	Sometimes (If so, when?)
Avoid certain textures (sand, mud, foods, lotions, etc.)	☐	☐	
Strongly dislike having hair washed, combed, or brushed	☐	☐	
Strongly dislike having dirty hands	☐	☐	
Trouble tolerating touching, hugging, or cuddling	☐	☐	
Prefer to wear only certain types of clothes	☐	☐	
Frequently walk on tiptoes	☐	☐	
Overly sensitive to sounds (put hands over ears)	☐	☐	
Become easily distracted by environmental sounds	☐	☐	
Frequently chew on clothes or objects	☐	☐	
Avoid eating certain types of textures or foods	☐	☐	
Overly sensitive to smells	☐	☐	
Bothered by certain sounds (e.g., other people chewing)	☐	☐	

Have you ever had any of the following problems?	Yes	No	Sometimes (If so, when?)
Poor balance	☐	☐	
Poor motor coordination	☐	☐	
Use too much or too little pressure with objects	☐	☐	
Difficulty with puzzles, colors, and shapes	☐	☐	
Blink excessively when trying to catch balls or balloons	☐	☐	

Have you ever exhibited any of the following behaviors?	Yes	No	Sometimes (If so, when?)
Head-banging	☐	☐	
Hair-twirling	☐	☐	
Hair plucking, pulling, or skin-picking	☐	☐	
Hand-flapping	☐	☐	
Twirling	☐	☐	
Twitching or excessive eye blinking	☐	☐	
Throat clearing	☐	☐	
Excessive worrying or fearing	☐	☐	
Worrying about dirt or germs	☐	☐	
Needing to carry out certain rituals	☐	☐	
Feeling you must be perfect	☐	☐	
Liking things to be very neat and clean	☐	☐	
Arguing a lot	☐	☐	
Sad, unhappy, depressed	☐	☐	
Irritable	☐	☐	
Hitting other people	☐	☐	
Frequent temper tantrums	☐	☐	

Any other sensory, motor or movement concerns that have not been listed? If yes, please describe them:

_____

_____

SOCIAL HISTORY

Please answer the following:	Yes	No	If yes, please describe:
Have you ever had trouble starting or stopping an activity?	☐	☐	
Have you ever had difficulty interpreting or using eye contact, facial expressions, or gestures?	☐	☐	
Have you ever had trouble participating in back-and-forth conversation?	☐	☐	
Do you enjoy socializing with others currently?	☐	☐	
Have you ever had trouble developing and/or maintaining friendships?	☐	☐	
Have you ever had trouble with changes in activities or routines?	☐	☐	
Have you ever harmed an animal or another person?	☐	☐	
Have you ever had a specific interest in fire, especially starting fires?	☐	☐	
How many close friends do you have? (Please specify if different during childhood)	☐	☐	
Have you had any trouble developing romantic or intimate relationships, if you have been interested?	☐	☐	

Any other past social concerns that have not been listed? If yes, please describe them:

_____

_____

ACADEMIC/SCHOOL HISTORY

Highest Degree Completed: _____

Please list all the schools you have attended (including high schools, trade/technical schools, and/or any colleges/ universities attended).

School Name & Location	**Grades/Dates Attended**	**Classroom Type** (e.g., special education, regular classroom, gifted)	**Supports provided** (e.g., classroom aide, speech therapy)

Do you remember ever having any of the following issues?	**Yes**	**No**	**Explanation**
Difficulty learning to read	☐	☐	
Difficulty reading	☐	☐	
Read slowly	☐	☐	
Problems understanding what you read	☐	☐	
Problems with spelling	☐	☐	
Rely on a spell checker to produce an adequate document	☐	☐	
Difficulty writing book reports and term papers	☐	☐	
Difficulty in forming concepts to write about	☐	☐	
Difficulty in the mechanical aspects of writing	☐	☐	
Difficulty learning a foreign language	☐	☐	
Problems learning mathematics	☐	☐	

Please answer the following:	**Yes**	**No**	**Explanation**
Have you ever repeated or skipped/been accelerated through a grade? *If yes, which grade(s) and what was the reason?*	☐	☐	
Have you ever failed a course? *If yes, please explain.*	☐	☐	
Did you get along with classmates? *If no, please explain.*	☐	☐	
Have you ever been provided with an Individualized Education Program and/or Section 504 Plan for Accommodation? *If yes, please provide categorization, grade when established, and grade when it ended (if applicable).*	☐	☐	
Have you ever been told you have a learning disability? *If yes, please explain.*	☐	☐	
Have you been enrolled in an advanced or gifted curriculum? *If yes, please list subjects.*	☐	☐	
Did you get along with teachers? *If no, please explain.*	☐	☐	
What was your best/favorite subject in school?	☐	☐	
What subject was hardest for you in school?	☐	☐	
Do you read a daily newspaper/news online?	☐	☐	
Do you read the Sunday newspaper/news online?	☐	☐	

PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Have you ever seen:	Yes	No	Name(s)	Dates
A psychiatrist (MD)?	☐	☐		
A psychologist (PhD or PsyD)?	☐	☐		
A therapist (LPC, MSW, LMFT, etc.)?	☐	☐		
A speech/language therapist?	☐	☐		
An occupational or physical therapist?	☐	☐		
A neurologist (MD)?	☐	☐		

Please answer the following:	Yes	No	Description
Have you previously or currently exhibited low mood for extended periods of time (several days or weeks)? *If yes, please describe.*	☐	☐	
Have you ever been hospitalized for psychiatric reasons? *If yes, please describe the circumstances and give the dates of hospitalization.*	☐	☐	
Have you ever had educational, psychological, or neuropsychological testing? *If yes, please list the evaluator and the date(s) testing was done.*	☐	☐	
Any other testing?	☐	☐	
If prior testing completed, can you provide a copy of the report or allow us to request it?	☐	☐	

Any other past psychiatric/psychological concerns that have not been listed? If yes, please describe them:

_____

_____

MEDICAL HISTORY

Have you ever had any hospitalizations or operations? If yes, please list below.

Date	Hospital Name, City and State	Reason for Hospitalization

Have you ever experienced any of the following health concerns?

Please describe your nighttime habits:	
Does not like to go to bed	
Can't fall asleep	
Wake up in the middle of the night	
Wander around in the middle of the night	
Afraid of the dark	
Nightmares	
Wake up too early in the morning	
Very hard to wake up	
Snore	
Has pauses or interruptions in breathing while sleeping	
Bedwetting	
Fall asleep or get drowsy during the day	
Sleepwalking	
Repetitive dreams	
Limbs jerking wakes you up	

Medical Concern	**Yes**	**No**	**Describe**
Vision Problems	☐	☐	
Hearing Problems	☐	☐	
Ear Infections	☐	☐	
Allergies or sensitivities	☐	☐	
Headaches (if migraines please specify)	☐	☐	
Stomach Aches	☐	☐	
Strep Throat	☐	☐	
Heart, lung, kidney, or other kidney problems	☐	☐	
Diabetes	☐	☐	
Endocrine (e.g. Thyroid, growth problem, etc.)	☐	☐	
Concussion	☐	☐	
Moderate or Severe brain injury	☐	☐	
Seizure	☐	☐	
Lupus	☐	☐	
Multiple Sclerosis	☐	☐	
Dysautonomia	☐	☐	
Hypermobility syndromes (e.g. Connective Tissue disorders, Ehler's Danlos syndrome)	☐	☐	
Nicotine Use	☐	☐	
Sexual concerns	☐	☐	

Please answer the following questions:	Yes	No	Describe
Do you have a good appetite? *If no, please explain*.	☐	☐	
Do you require a special diet? *If yes, please explain.*	☐	☐	
Do you get enough exercise? *Please describe the kind and amount.*	☐	☐	
How many hours of sleep do you get each weeknight?	☐	☐	
How many hours of sleep do you get each night on weekends/holidays?	☐	☐	
Have you ever been abused or traumatized?	☐	☐	
Have you ever had any serious medical illness? *If yes, please explain.*	☐	☐	
Have you had any sporting or motor vehicle accidents? *If yes, please explain.*	☐	☐	

Please list any medications, supplements, or homeopathic remedies you may be taking.

Name of Medication	Strength	When Started	How many times per day

Please list any recreational substances you are currently using or have used:

Substance	Frequency	Quantity	How recently
Alcohol			
Marijuana			
Psychedelics			
Amphetamines (e.g., Cocaine, etc.)			
Opioids			
Other:			

☐ Please check here if you prefer to discuss at intake rather than indicate in writing.

Please list any medications you have taken in the *past*, except for antibiotics and decongestants:

Name of Medication	Reason Prescribed	Strength	When Started	Effect (Positive/Negative)

Any other medical concerns that have not been listed? If yes, please describe them:

_____

_____

EMPLOYMENT HISTORY

Please answer the following questions:

What is your current occupation? *Please specify Part-Time or Full-Time.*	
Are you a student? *Please specify Part-Time or Full-Time.*	
Are you currently unemployed? *Please specify how long you have been unemployed and the reason.*	
What is your present job title?	
Who is your current employer?	
How long have you worked there?	
How many hours do you work each week?	
What are some difficulties you have had in performing your current or past job?	
What are your past occupations, and what are the dates you worked there?	

LEGAL HISTORY

Please answer the following questions.	Yes	No	Please describe
Are you currently involved in any litigation?	☐	☐	
Have you ever been arrested?	☐	☐	

DRIVING HISTORY

Please answer the following questions.	Yes	No	Please describe
Do you currently have a driver's license?	☐	☐	
Has your driver's license ever been taken away?	☐	☐	
Have you ever been in an accident when you were driving?	☐	☐	
Do you like to drive fast?	☐	☐	
Do you find it hard to wait at red lights?	☐	☐	
Have you ever been stopped by the police for speeding? *If yes, indicate number of times.*	☐	☐	
Have you ever been arrested for driving under the influence? (DUI)	☐	☐	

PROFESSIONALS CURRENTLY PROVIDING CARE

Please note: To assure confidentiality, contact will not be made without a completed Authorization to Release/Request Information signed by the patient.

Name	Care Provided	Telephone Number	Fax Number	E-mail Address

Please provide any other pertinent information that was not adequately addressed in this form (continue onto the back if needed)