Lauri L. Korinek, Ph.D., LLC, PC
Licensed Psychologist, Neuropsychologist

9364 Teddy Lane, Suite 204
Lone Tree, Colorado 80124
(303) 804-5669 Phone
(303) 814-1109 Fax

Cognitive/Neuropsychological History Form

Client's name ________________________________ Date ______________

Age ______ Birthdate ______ Religion __________________ Sex ______

Medication ____

____

Hand client uses for writing / drawing: Right ____ Left ____ Switches ______

Mother's handedness RT or LFT Father's handedness RT or LFT

Primary language ____________________ Secondary language ______________

Medical diagnosis, if any (1) ______________________________________
(2) ______________________________________

Describe the problems, first major concerns and then minor ones. __________________

____

____

____

____

____

THIS FORM HAS BEEN COMPLETED BY:

Name ______________________________ Relationship to client ______________

Phone Number_______________________

SYMPTOM SURVEY

For each symptom that applies to the client, place a check in the box. Compare the client to other people of the same age. Then, check if this is a NEW symptom (within the past year) or an OLD symptom (over one year). Add any helpful comments next the item.

1) **PROBLEM SOLVING**

√	New	Old	
□	___	___	Difficulty figuring out how to do new things
□	___	___	Difficulty making decisions
□	___	___	Difficulty solving problems a younger client can do
□	___	___	Difficulty understanding explanations
□	___	___	Difficulty doing things in the right order (sequencing)
□	___	___	Difficulty verbally describing the steps involved in doing something
□	___	___	Difficulty completing an activity in a reasonable period of time
□	___	___	Difficulty changing a plan or activity when necessary
□	___	___	Is slow to learn new things
□	___	___	Difficulty switching from one activity to another activity
□	___	___	Easily frustrated
□	___	___	Other problem solving difficulties ______________________________

2) **SPEECH, LANGUAGE, AND MATH SKILLS**

√	New	Old	
□	___	___	Difficulty speaking clearly
□	___	___	Difficulty finding the right word to say
□	___	___	Not talking
□	___	___	Rambles on and on without saying much
□	___	___	Jumps from topic to topic
□	___	___	Odd or unusual language or vocal sounds
□	___	___	Difficulty understanding what others are saying
□	___	___	Difficulty understanding what he/she is reading
□	___	___	Difficulty writing letters or words
□	___	___	Difficulty reading letters or words
□	___	___	Difficulty with spelling
□	___	___	Difficulty with math
□	___	___	Other speech, language, or math problems: ________________

3) **SPATIAL SKILLS**

√	New	Old	
□	___	___	Confusion telling right from left
□	___	___	Has difficulty with puzzles, Legos, blocks, or similar games
□	___	___	Problems drawing or copying
□	___	___	Doesn't know his/her colors
□	___	___	Difficulty dressing (not due to physical difficulty)
□	___	___	Problems finding his/her way around places he/she has been to before
□	___	___	Difficulty recognizing objects

□ ___ ___ Seems unable to recognize facial or body expressions of disapproval or emotions
□ ___ ___ Gets lost easily
□ ___ ___ Other spatial problems: ______________________________

4) **AWARENESS AND CONCENTRATION**

√ New Old
□ ___ ___ Easily distracted by: Sounds ___ Sights ___ Physical sensations __
□ ___ ___ Mind appears to go blank at times
□ ___ ___ Loses train of thought
□ ___ ___ Difficulty concentrating on what others say, but can sit in front of a TV for long periods
□ ___ ___ Attention starts out OK but can't keep it up
□ ___ ___ Other attention or concentration problems: _____________________

5) **MEMORY**

√ New Old
□ ___ ___ Forgets where he/she leaves things
□ ___ ___ Forgets things that happened recently (e.g., last meal)
□ ___ ___ Forgets things that happened days/weeks ago
□ ___ ___ Forgets what he/she is supposed to be doing
□ ___ ___ Forgets names more than most people do
□ ___ ___ Forgets school assignments
□ ___ ___ Forgets instructions
□ ___ ___ Other memory problems: __________________________________

6) **MOTOR AND COORDINATION**

check the side this occurs on:

Check if this occurs on:

√	New	Old		Right	Left	Both
□	___	___	Poor fine motor skills (e.g., using a pencil or cray	_____	_____	_____
□	___	___	Clumsy	_____	_____	_____
□	___	___	Weakness	_____	_____	_____
□	___	___	Tremor			
□	___	___	Muscles are tight or spastic	_____	_____	_____
□	___	___	Odd movements (posturing, peculiar hand movements, etc.)			
□	___	___	Drops things more than most clientren			
□	___	___	Has an unusual walk			
□	___	___	Balance problems			
□	___	___	Other motor or coordination problems: ___________________________________			

7) **SENSORY**

check the side this occurs on:

√	New	Old		Right	Left	Both
□	___	___	Needs to squint or move closer to page to read			
□	___	___	Problems seeing objects	_____	_____	_____

□ ___ ___ Loss of feeling ____ ____ ____
□ ___ ___ Problems hearing sounds
□ ___ ___ Difficulty telling hot from cold
□ ___ ___ Difficulty smelling odors
□ ___ ___ Difficulty tasting food
□ ___ ___ Overly sensitive to: Touch____ Light____ Noise_____
□ ___ ___ Other sensory problems:___________________________________

8) **PHYSICAL**

√	New	Old		How often?
□	___	___	Frequently complains of headaches or nausea	___________________
□	___	___	Has dizzy spells	___________________
□	___	___	Has pains in joints Where?_____________________________________	
□	___	___	Excessive tiredness	
□	___	___	Frequent urination or drinking	
□	___	___	Other physical problems: ____________________________________	

9) **BEHAVIOR**

√	New	Old		√	New	Old	
□	___	___	Aggressive	□	___	___	Nervous
□	___	___	Attached to things, not people	□	___	___	Quiet
□	___	___	Bedwetting	□	___	___	Unmotivated
□	___	___	Bizarre behavior	□	___	___	Resists change
□	___	___	Bowel movements in underwear	□	___	___	Risk-taking
□	___	___	Dependent	□	___	___	Self-mutilates
□	___	___	Depressed	□	___	___	Self-stimulates
□	___	___	Eating habits are poor	□	___	___	Shy and withdrawn
□	___	___	Emotional	□	___	___	Sleeping habits are poor
□	___	___	Fearful	□	___	___	Swears a lot
□	___	___	Immature	□	___	___	Nightmares, night terrors, sleepwalks

□ ___ ___ Other unusual behavior: _______________________________________

Below, circle the number that best describes your client's behavior and has been present for at least the **past 6 months**. 0 = Never or very rarely, 1= Sometimes, 2= Often, 3= Very often or almost always.

Fails to give close attention to details or makes careless mistakes ………...	0	1	2	3
Has difficulty sustaining attention in tasks or activities ……………………………..	0	1	2	3
Does not seem to listen when spoken to directly ……………………………………….	0	1	2	3
Does not follow through on instructions and fails to finish work ………………………...	0	1	2	3
Has difficulty organizing tasks and activities ……………………………………………..	0	1	2	3
Avoids tasks (e.g., schoolwork) that require mental effort ……………………………….	0	1	2	3
Loses things necessary for tasks or activities ……………………………………………..	0	1	2	3
Is easily distracted ……………………………………………………………………...	0	1	2	3
Is forgetful in daily activities ……………………………………………………………...	0	1	2	3
Fidgets with hands or feet or squirms in seat ……………………………………………...	0	1	2	3

Leaves seat in situations in which remaining seated is expected …..	0 1 2 3
Runs about or climbs excessively in situations in which it is inappropriate ....…..	0 1 2 3
Has difficulty playing or engaging in leisure activities quietly ……………………………	0 1 2 3
Is "on the go" or act as if "driven by a motor" ……………………………………………	0 1 2 3
Talks excessively ……………………………………………………………………………..	0 1 2 3
Blurts out answers before questions have been completed ……………………………..	0 1 2 3
Has difficulty awaiting turn …………………………………………………………………	0 1 2 3
Interrupts or intrudes on others ………..……………………...……………………..	0 1 2 3
Loses temper ……..…………………………………………………………………….….	0 1 2 3
Argues with others …………………………………………………………………………	0 1 2 3
Actively defies or refuses to comply with adults' requests or rules ………………………	0 1 2 3
Deliberately annoys people ………………………………………………………………....	0 1 2 3
Blames others for his/her mistakes or misbehaviors ………………………………………	0 1 2 3
Is touchy or easily annoyed by others ……………………………………………………	0 1 2 3
Is angry and resentful ………………………………………………………………………	0 1 2 3
Is spiteful or vindictive ………………………………………………………………....	0 1 2 3

Below, check all the descriptions of the client that have been present for at least the past 6 months and 12 months. These behaviors should occur more frequently than in other individuals of the same age:

6 Months

___ Is very fidgety
___ Can't remain seated
___ Doesn't listen to other people
___ Highly distractible
___ Is often rude or interrupts others
___ Can't wait for his/her turn when playing with others
___ Answers before he/she hears the whole question
___ Rarely follows others' instructions
___ Has a hard time concentrating for long periods
___ Goes from one activity to another without finishing anything
___ Frequently makes noise when playing
___ Has forceable sexual relations with others
___ Seems like he/she is always talking
___ Seems like he/she frequently is losing things that are needed for school
___ Frequently does dangerous things without considering the consequences

12 Months

___ Steals things without people knowing on several occasions
___ Often runs away from his/her home and stays away overnight
___ Starts fights with others
___ Easily lies to others
___ Firesetting
___ Breaks into other people's property
___ Is cruel to animals
___ Will steal directly from people
___ Is cruel to other people
___ Destroys other people's property in some manner other than by fire
___ When fighting, has used a weapon on more than 1 occasion

10) Overall, the client's symptoms have developed: ___ Slowly ___ Quickly

11) The symptoms occur: ___ Occasionally ___ Often

12) Over the past 6 months the symptoms have: ___ Stayed about the same ___ Worsened

PREGNANCY

13) Mother's age at client's birth:_______________ Father's age at client's birth:_____________

14) **Before** the pregnancy, what medications (prescribed or over-the-counter) did the mother take?
List all medications used:____

15) **While** pregnant, what medications (prescribed or over-the-counter) did the mother take?
List all medications used:____

16) How often did the mother see her doctor during the pregnancy?
Regularly (as scheduled by the doctor)_____ Rarely______ Not at all______

17) During the pregnancy, which of the following did the mother use?

	Amount and Daily Frequency
______ Alcohol	______________________________
______ Caffeine (coffee, colas, etc.)	______________________________
______ Marijuana	______________________________
______ Recreational drugs (cocaine, heroin, etc.)	______________________________
______ Tobacco	______________________________

18) During the pregnancy, the mother's diet was: Good _______ Poor ________
If poor, explain:____

19) The mother's general physical health during the pregnancy was: Good ______ Poor ________
If poor, explain:____

20) About how much weight did the mother gain while she was pregnant? ____________ lbs.

21) During this pregnancy, check all the mother had:
________ Accident
________ Anemia
________ Bleeding (severe or frequent spotting)
________ Preeclampsia, eclampsia, or toxemia
________ Surgery
________ Diabetes
________ High blood pressure
________ Illnesses or infections
________ Psychological problems
________ Vomiting (severe or frequent)

22) How many pregnancies did the mother have prior to this one?
Number of live births: _______
Number of miscarriages: _____

BIRTH

23) Was this client born:
Early __ How early? ________ weeks
On time __ (38 - 42 weeks)
Late __ How late? ________ Weeks

24) How much did the client weigh at birth? ______ lbs. ______ oz. OR ______ gms.

25) How long did the labor last? ____

26) The labor was: Easy _______ Moderately difficult ________ Very difficult _______

27) What type of medication was the mother given to help with delivery? None______
Demerol _____Gas _____ Regional nerve (spinal) block _____ Tranquilizer _____ Epidural _____

28) Were forceps used during delivery? Yes ________ No ________

29) Was the client born:
Head first _____ Transverse (crosswise) _____ Posterior first _____
Breech birth _____ Caesarean section _____ Vacuum extraction _____
Other: ____

30) Did the client experience any of these problems:
Fetal distress _____ Low placenta (Placenta previa) _____ Prolapsed cord _____
Premature separation of placenta (Abruptio placenta) _____ Cord wrapped around neck _____

31) Describe any other special problems the mother or client had during delivery:
____
____

32) At birth, did the client:
Have difficulty breathing? Yes _____ No _____
Fail to cry? Yes _____ No _____
Appear inactive? Yes _____ No _____

33) List the client's Apgar scores: 1st _________ 2nd _________

34) If the father or mother noticed anything unusual when they first saw the client, describe:
____

35) If the client was born with any problems (congenital defects, large or small head, blue client, bleeding in brain, etc.), describe: ____

36) Describe any special problems that the client had in the first few days following birth:
____

37) Describe any special care, treatment, or equipment the client was given after birth:
____

38) How long did the client stay in the hospital? ____

DEVELOPMENTAL HISTORY

For each area, indicate the client's health by circling one description. The "Average" period is only a rough idea of what is average since every developmental milestone actually involves a range of several months (e.g., walking occurs approximately 9-18 months of age). Circle "Early" or "Late" only if you are sure the client's development was different from that of most other clientren.

GROSS MOTOR SKILLS

Crawled	Early	Average (6-9 months)	Late
Walked alone (2-3 steps)	Early	Average (9-18 months)	Late

LANGUAGE

Followed simple commands	Early	Average (12-18 months)	Late
Used single-word sentences	Early	Average (12-24 months)	Late

SELF-HELP

Toilet trained	Early	Average (13-36 months)	Late

40) List any other significant developmental problems:____
____

41) Overall, the client's development was: Early _______ Average _______ Late _______

42) As an infant or toddler, did the client have poor muscle control (i.e., weakness) of the:
Neck _______ Trunk _______ Legs _______ Arms _______

43) As an infant or toddler, did the client's muscles seem to be unusually tight or stiff?
Yes _____ No _____ If yes, describe:____

44) Toilet training was: Easy _______ Difficult _______

45) As an infant or toddler, the client was:
- Too calm and inactive _______
- Calm and reasonably active _______
- Irritable and very active _______

46) As a toddler, the client was:
- Shy and inhibited _______
- Neither shy nor outgoing _______
- Very outgoing and like people _______

HEALTH HISTORY

47) Did the client have a poor appetite as a child? Yes _____ No _____

48) Did the client fail to gain weight steadily as a child? Yes _____ No _____

49) List the client's illnesses or physical problems during the first year:___________________________
____

50) Has the client had a temperature of 104°F (40°C) or higher for more than a few hours?

Yes _____ No _____ If yes, what age(s)? __________ and how long did it last ___________

51) Has the client ever been hit hard on the head or suffered a head injury? Yes _____ No ____
If yes, what age(s)? ___________ Did the client lose consciousness? Yes _____ No ____
How did it happen? ____
What problems did the client have (physical or mental) afterwards? ______________________

Did the client ever have a seizure due to a fever or unknown cause? Yes ____ No ____
If yes, describe (age, nature of seizure): ______________________________

52) Has the client been diagnosed with seizures or epilepsy? Yes _____ No ____
If yes, which type? Partial seizure _____ Generalized seizure _____ Unclassified type ____
If medication is used, what medication(s)? ______________________________
Has the client ever had a bad reaction to this medication? Yes _____ No ____
If yes, describe: ____

53) Was the client ever in the hospital for an accident, injury, or operation? Yes _____ No ____
If yes, what age(s)? _______ What happened? __________________________

54) Has the client ever swallowed any poison, non-food, or drug accidentally? Yes _____ No ____
If yes, what age(s)? _______ What happened? __________________________

55) Did the client have frequent ear infections? Yes _____ No ____
If yes, what age(s)? _______ How often and severe? ______________________
What treatment was provided? ______________________________________

56) Please check all the following diseases or conditions the client has ever had:

____ Allergies	____ Cerebral palsy	____ Jaundice	____ Mumps
____ Anemia	____ Chicken pox	____ Kidney disorder	____ Oxygen deprivation
____ Asthma	____ Colds (excessive)	____ Leukemia	____ Pneumonia
____ Bleeding disorder	____ Diabetes	____ Liver disorder	____ Rheumatic fever
____ Blood disorder	____ Encephalitis	____ Lung disorder	____ Scarlet fever
____ Brain disorder	____ Enzyme deficiency	____ Measles	____ Tuberculosis
____ Broken bones	____ Genetic disorder	____ Meningitis	____ Venereal disease
____ Cancer	____ Heart disorder	____ Metabolic disorder	____ Whooping cough

____Other problems: ____

57) As the client grew up, he/she had been sick:
Much of the time ______ An average amount ______ Not much at all _____

58) List all medication the client takes now:

Medication	**Dosage**	**How often?**	**What for?**
__________________	________________	________________	__________________
__________________	________________	________________	__________________

59) Does the client:
Wear glasses? Yes_____ No_____ (Farsighted_____ Nearsighted _____ Other_____)
Use a hearing aid? Yes_____ No_____

60) Within the past year, has the client had: **Results**
A vision test? Yes_____ No_____ ______________________________
A hearing test? Yes_____ No_____ ______________________________

61) What is the client's: Height ______ft. ______ in. Weight ________lbs.

62) When was the client last medical check-up?
____

63) What therapies have been provided to the client? ________ No Therapies
______ Occupational therapy
______ Physical therapy
______ Psychological therapy, counseling, or cognitive rehabilitation
______ Speech therapy
______ Other therapy: ____

FAMILY HISTORY

64) The client lives with:
_____ Parents _____ Relatives _____ Alone _____ Family
_____ One Parent _____ Children _____ Partner
_____ Other ____

65) What is the name of the client's biological mother? ____
a. Is she living? Yes _____ No _____ If deceased, explain: _____________________________
b. Her age? ____
c. What is her level of education? ____
d. Her occupation? ____
e. Does she live in the same house as the client? Yes _____ No _____
f. How often does she see the client? ____
g. How involved is the mother in the client's upbringing? Very ___Somewhat ____ Not at all_____
h. Did the mother have a learning disability or other problems when she was in school? Yes __No __
If yes, describe: ____
i. What are the mother's hobbies? ____

66) What is the name of the client's biological father? ____
a. Is he living? Yes _____ No _____ If deceased, explain:___________________________________
b. His age?____
c. What is his level of education? ____
d. His occupation? ____

e. Does he live in the same house as the client? Yes _____ No _____
f. How often does he see the client? ____
g. How involved is the father in the client's upbringing? Very _____ Somewhat _____ Not at all _____
h. Did the father have a learning disability or other problems when he was in school? Yes ___ No ___
If yes, describe:____
i. What are the father's 's hobbies? ____

67) Please list the names, ages, and grade (or job) of the client's brothers and sisters:

Name	**Age**	**Grade or Job**

68) Has anyone in the client's biological family (including parents, grandparents, siblings, cousins, aunts & uncles) ever had any of the following:

	Which relative?	**Describe the problem briefly**
_____ Brain disease		
_____ Developmental delay		
_____ Epilepsy or seizures		
_____ Learning disability		
_____ Mental retardation		
_____ Neurologic disease		
_____ Psychological problems		
_____ Reading/spelling difficulties		
_____ Speech/language problems		

69) Which of the client's biological relatives are left-handed?
Mother _____ Father _____ Sibling(s) _____ Grandparents _____ No one _____

70) What languages are/were spoken in the home? (List in order of the most frequent first.)
(1) ________________________________ (2) ________________________________

71) How is/was the client disciplined? ____
72) List the client's usual recreational activities and hobbies:
____
73) Have there been any major family stresses or changes in the past year (e.g., moving with change of school, divorce, significant illness, etc.)? Yes _____ No _____
If yes, please explain: ____
How much stress have these changes caused the client? (circle one) None Mild Moderate Severe

SCHOOL HISTORY

75) Please summarize the client's progress (e.g., academic, social, testing) within each of these grade levels (include school name, if possible):

Preschool ____
____

Kindergarten ____
____

Elementary School ____
____

Middle School ____
____

High School ____
____

Additional Education ____
____

76) Has the client ever been in any type of special educational program, and if so, how long? (If yes, please explain.)

______ Learning disabilities class
______ Duration of placement
______ Behavioral/emotional disorders class
______ Duration of placement
______ Speech & language therapy
______ Duration of therapy
______ Other (please specify)
______ Duration

77) Has the client ever been: (If yes, please explain.)

______ Suspended from school
______ Number of suspensions
______ Expelled from school
______Number of expulsions
______ Retained in grade
______ Number of retentions

78) Have any additional instructional modifications been attempted? (If yes, please explain.)

______ None
______ Behavior modification program
______ Daily/weekly report card
______ Occupational Therapy
______ Tutoring
______ Other (please explain): ____

79) Did the client like school? Most of the time ______ Sometimes ______ Almost never

80) Did the client:

Have problems with other students in class?	Yes _____	No _____
Have problems making friends in school?	Yes _____	No _____
Have problems getting along with teachers?	Yes _____	No _____
Tend to get sick in the morning before school?	Yes _____	No _____

81) Describe any teacher concerns about the client's schoolwork or behavior:________________
____
____

82) What kind of grades did the client received in school?

A's & B's ______ B's & C's ______ C's & D's ______ D's & F's ______

or

Outstanding ____ Good ____ Satisfactory ____ Improvement needed ____ Unsatisfactory ____

or

Other grading system: ____

83) Have/Did these grades change over her/his school years? Yes _____ No ____

84) How much school did the client miss due to illness or injury?

Less than 2 weeks ____ 2 to 4 weeks ____ 5 to 8 weeks _____ Over 8 weeks _____

Briefly describe the reasons if the client missed a lot of school: ___________________________
____

85) Does/Did the client seem to have a "school phobia"? Yes _____ No _____

If yes, explain: ____
____

SOCIAL HISTORY

86) How does the client get along with his/her brothers/sisters?

_____ Does not have any
_____ Worse than average
_____ Average
_____ Better than average

87) How easily does the client make friends?

_____ Do not know
_____ Worse than average
_____ Average
_____ Easier than average

88) On the average, how long does client keep friendships?

_____ Less than 6 months
_____ 6 months to 1 year
_____ More than 1 year
_____ Don't know

PREVIOUS EVALUATIONS

89) Which of these tests or procedures recently have been done? Note any abnormal findings.

Evaluation	Check here if normal	Abnormal findings
_____ Blood work	_____________	_________________
_____ Family physician or pediatrician office visit	_____________	_________________
_____ Hearing testing	_____________	_________________
_____ Lead level check	_____________	_________________
_____ Lumbar puncture or spinal tap	_____________	_________________
_____ Neurological examination or testing (CT scan, EEG)	_____________	_________________
_____ Psychological or neuropsychological testing	_____________	_________________
_____ School testing	_____________	_________________
_____ Speech & language testing	_____________	_________________
_____ Vision testing	_____________	_________________
_____ X-rays	_____________	_________________

_____ Other tests: ____
____

THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE.
Please fax this report to Lauri L. Korinek at 303-814-1109 or scan and email to Lauri@HopeandGrowth.pro

____ ________________________________
Client's or Guardian's Signature Date

THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE.
Please return this document to Lauri L. Korinek Ph.D., LLC.