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

9364 Teddy Lane, Suite 204
Lone Tree, Colorado 80124
(303) 324-0451 Phone
1-800-863-6549 Fax

Cognitive/Academic/Neuropsychological History Form

Client's name _____ Date _____

Age _____ Birthdate _____ Religion _____ Sex _____

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, child, partner, or you) 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 others can
□	___	___	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
□	___	___	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
□	___	___	Rarely talks
□	___	___	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 emotions

□ ___ ___ Gets lost easily
□ ___ ___ Other visual or 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 maintain it
□ ___ ___ Other attention or concentration problems: _____

5) **MEMORY**

√ New Old

□ ___ ___ Forgets where he/she/I leave(s) things
□ ___ ___ Forgets things that happened recently (e.g., last meal)
□ ___ ___ Forgets things that happened days/weeks ago
□ ___ ___ Forgets what he/she/I is(am) supposed to be doing
□ ___ ___ Forgets names more than most people do
□ ___ ___ Forgets to complete school/job tasks
□ ___ ___ Forgets instructions
□ ___ ___ Other memory problems: _____

6) **MOTOR AND COORDINATION**

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

7) **SENSORY**

√	New	Old		check the side this occurs on: 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, child's, partner's, own) 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, pay bills) 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 behavioral 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 12 months. These behaviors should occur more frequently than in other individuals of the same age:

___ Steals things without people knowing on several occasions
___ Easily lies to others
___ Is often rude
___ Starts fights with others
___ Firesetting
___ Rarely follows others' instructions
___ Breaks into other people's property
___ Is cruel to animals
___ Is cruel to other people
___ Destroys other people's property
___ Frequently does dangerous things without considering the consequences

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, please describe:

_____

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

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^{o}F (40^{o}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's 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: _____

PSYCHIATRIC HISTORY

Outpatient Treatment ( ) Yes ( ) No If yes, please provide information about diagnoses and treatment.

_____
_____
_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, please provide information about diagnoses and treatment.

_____
_____
_____

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No	Depression	( ) Yes ( ) No
PTSD	( ) Yes ( ) No	Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

SUBSTANCE USE HISTORY

Please list substances you have used and complete the chart for each.				
Substance	**First Use**	**Last Use**	**Frequency/ Amount**	**Do you consider your usage to be a problem, currently?**
Alcohol				
Cannabis				
Prescription Drugs (abuse)				
Other (please specify)				
Other (please specify)				
Other (please specify)				

Please list your favorite substance and an explanation about what you like about it.

Has anyone in the client's biological family (including parents, grandparents, siblings, cousins, aunts & uncles) ever had substance use problems:

Substance	**If comfortable, please provide family member(s)**
__Alcohol	_____
__Cannabis	_____
__Other:_____	_____
__Other:_____	_____

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. How often did/does she see the client? _____
f. How involved was/is the mother in the client's upbringing? Very ___Somewhat ____Not at all_____
g. Did the mother have a learning disability or other problems when she was in school? Yes __No __
If yes, describe: _____
h. What were/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. How often did/does he see the client? _____
f. How involved was/is the father in the client's upbringing? Very _____ Somewhat _____Not at all___
g. Did the father have a learning disability or other problems when he was in school? Yes ___ No ____
If yes, describe:_____
h. What were/are the father's hobbies? _____

67) Please list the names, ages, highest educational level completed, and occupation of the client's brothers and sisters:

Name	**Age**	**Education**	**Occupation**
_____	_____	_____	_____

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 was/is 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, job change, 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

EDUCATIONAL HISTORY

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

Preschool _____
_____

Kindergarten _____
_____

Elementary School _____
_____

Middle School (or Junior High School) _____
_____

High School _____

College_____

Post Graduate_____

Additional Educational Experiences (e.g., specialized training, residency)_____

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 evaluation
_____ Occupational Therapy
_____ Tutoring/Supervision
_____ 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 (past or present) about the client's schoolwork or behavior:_____

82) What kind of grades did/does 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 has/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: _____
_____

EMPLOYMENT HISTORY

As best as you are able please provide a chronological list of employment. Please start with most recent employment:

Dates of Employment: Employer:
Position: Responsibilities:

Dates of Employment: Employer:
Position: Responsibilities:

Dates of Employment: Employer:
Position: Responsibilities:

Dates of Employment: Employer:
Position: Responsibilities:

Dates of Employment: Employer:
Position: Responsibilities:

What do you like about your current employment?_____
_____
What do you dislike about your current employment?_____
_____

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	_____	_____
_____ 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 return this document to Lauri L. Korinek Ph.D., LLC, at:

9364 Teddy Lane, Suite 204
Lone Tree, Colorado 80124
(303) 324-0451 Phone
1-800-863-6549 Fax

_____ _____
Client's or Guardian's Signature Date