Edelson & Associates, P.S.C.

NEUROPSYCHOLOGICAL, PSYCHOLOGICAL & FAMILY SERVICES

7511 New LaGrange Road
Louisville, KY 40222
Phone: (502) 423-1151
Fax: (502) 423-1748

BACKGROUND INFORMATION

PERSONAL DATA

Patient's Name: _____ **Today's Date:** _____

Birth Date: _____ **Age:** _____ **Sex (Circle One):** **Male** **Female**

Handedness (Circle One): **Right** **Left**

Home Address: _____ **Phone:** _____

_____

Place of Employment: _____

Address: _____

Position / Title: _____

Length of Current Employment or Retirement: _____

Person filling out this form (circle one): **Self** **Spouse**

Other: (please explain) _____

FAMILY DATA

Marital Status: (circle one) **Single** **Married** **Widowed** **Divorced**

Number of Marriages: _____ **Length of Current Marriage/Relationship:** _____

Spouse/Significant Other Name: _____ **Age:** _____

Name of Spouse's Employer: _____

Spouse's Position/Title: _____

Children (names and ages): _____

_____

_____

List all people living in household:

Name	*Relationship to Patient*	*Age*

Names and ages of parents, including stepparents. If deceased, please note and identify age at time of death and cause of death: _____

_____

If parents separated/divorced, how old was patient when the separation/divorce occurred? ___

_____

Names and ages of brothers/sisters. If deceased, please note and identify age at time of death and cause of death: _____

_____

EDUCATIONAL HISTORY

Highest Grade Completed: _____ **Last year of schooling:**_____

Last School Attended: _____

Degrees Obtained and year (if applicable): _____

Grade point average, or typical letter grades obtained: _____

List any learning difficulties you had in school: _____

_____

_____

EMPLOYMENT HISTORY

Please list all employers for the last three years and the position/title held by you; if retired, please list last place of employment: _____

_____

List any Difficulties with Current Employer or Coworkers _____

_____

Military History/Rank/Years of Service: _____

_____

MEDICAL HISTORY

Place a check next to any illness or condition that you have had. When you check an item, note the approximate year (or age) of the illness. *Use the back of this page to provide more details.*

Check	*Illness/Condition*	*@Year/Age*	*Check*	*Illness/Condition*	*@Year/Age*
____	Measles	____	____	Frequent/Severe Headaches	____
____	German Measles	____	____	Difficulty Concentrating	____
____	Mumps	____	____	Memory Problems	____
____	Chicken Pox	____	____	Extreme Tiredness/Weakness	____
____	Whooping Cough	____	____	Rheumatic Fever	____
____	Diphtheria	____	____	Scarlet Fever	____
____	Meningitis	____	____	Epilepsy/Seizures	____
____	Encephalitis	____	____	Tuberculosis	____
____	High Fever	____	____	Bone/Joint Disease/Arthritis	____
____	Convulsions	____	____	Sexually Transmitted Disease	____
____	Allergy	____	____	Anemia	____
____	Hay Fever	____	____	Jaundice/Hepatitis	____
____	Injuries to Head	____	____	Diabetes	____
____	Broken Bones	____	____	Cancer	____
____	Hospitalizations	____	____	High Blood Pressure	____
____	Operations/Surgeries	____	____	High Cholesterol	____
____	Visual Problems	____	____	Heart Disease	____
____	Fainting Spells	____	____	Bleeding Problems	____
____	Paralysis	____	____	Suicide Attempt	____
____	Dizziness	____	____	Asthma	____
____	Sleep Disturbance	____	____	Illicit Drug Use	____
____	Loss of Consciousness	____	____	Nervous/Psychological Prob.	____
____	Alcoholism	____	____	Learning Problems	____
____	Tobacco Use	____	____	Injury from Vehicular Accident	____
____	Depression			Appetite Normal Yes No	
____	Ear Problems (disease, infection, injury or impaired hearing)	____		Height ____ Weight ____	

Were there any special problems in your growth and development during the first few years?

Yes/No, if Yes, please provide details _____

_____

List any past hospitalizations, and approximate dates? _____

_____

_____

List all physicians consulted in the past two years: _____

_____

List all medications and dosages currently being taken, along with any side effects: _____

_____

PRESENTING PROBLEM

***Please note: If you are using your insurance benefits to cover the costs of an evaluation, then a physician must receive a report from us in order to meet the "medical necessity" regulations as required by your insurance company. Otherwise, your insurance company may deny coverage and require you to pay the full cost of our services*.**

Referring Physician, include first and last name, and address or telephone number:

_____

_____

Describe problems you are presently having: _____

_____

_____

Are any of your family members reporting similar problems? _____

_____

When did problems begin? _____

_____

What have you done to try to solve/deal with problems? _____

_____

Additional information you think we should know: _____

_____

_____