Catherine Wood, Ph.D.
*Clinical Neuropsychologist*

# *New Patient Intake Form*

**Form Completed By:** _____ **Date:** _____

## 1. Patient Identifying Information

**Full Name:** _____

**Date of Birth:** _____ **Age:** _____

**Handedness:** ◯ Right-handed ◯ Left-handed ◯ Mixed / Ambidextrous

**Race / Ethnicity:** _____

**Sex / Gender Identity:** _____

**Preferred Language:** _____

**Why were you referred / sent for this evaluation?**

_____

_____

## 2. History of Cognitive Concerns

**Do you have any concerns or problems with your thinking skills or cognition?** ◯ YES ◯ NO

*If yes, when did this start?* _____

**Please describe your specific cognitive concerns or problems in detail:**

_____

_____

_____

_____

_____

## 3. Medical History

**<u>Current</u> Medical Problems:**

_____

_____

_____

Located inside SC Neuro, 29 Leinbach Dr, Ste D4, Charleston SC 29407
Ph: 843-212-6801 | Fax: 877-860-2686
office@woodphd.com | practice.woodphd.com

**<u>Past</u> Medical Problems & Surgeries:**

_____

_____

_____

**Do you take your medications independently?** ◯ YES ◯ NO

*If no, who assists you?* _____

**Medications & Supplements:**

*Please list all current prescription medications, over-the-counter (OTC) drugs, and vitamins / supplements.*

| | Prescribed or OTC Medication / Supplement | Dosage & Frequency |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

**Hospitalizations & Emergency Room Visits:**

**Have you <u>ever</u> been treated in an emergency room or hospital?** ◯ YES ◯ NO

*If yes, please list the details below:*

| Hospital / Location | Dates of Visit | Condition / Reason for Visit |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Have you had a head injury where you were knocked unconscious, dazed, or confused?** ◯ YES ◯ NO

*If yes, please list the dates and details:*

_____

_____

**Do you snore or gasp for breath while sleeping?** ◯ YES ◯ NO

**Have you <u>ever</u> had any of the following tests?** *(Check **<u>all</u>** that apply)*

☐ Head CT / Brain MRI ☐ EEG ☐ Spinal Tap ☐ Genetic Testing ☐ Neuropsychological Testing

*If yes, when and where?*

_____

_____

**Have you <u>ever</u> received Rehabilitation Services?**

**Inpatient Rehab:** ◯ YES ◯ NO → *If yes, please describe:*

_____

**Outpatient Rehab:** ◯ YES ◯ NO → *If yes, please describe:*

_____

**Do you <u>currently</u> experience chronic pain or other physical problems?** ◯ YES ◯ NO

*If yes, please describe:*

_____

_____

**Have you been exposed to toxins (e.g., pesticides, lead) in your home or workplace?** ◯ YES ◯ NO

*If yes, what toxins and dates?*

_____

_____

**Do you have a <u>family history</u> of medical, neurological, or mental health problems?** ◯ YES ◯ NO

*If yes, please list the conditions and relatives (e.g., dementia: maternal grandmother):*

_____

_____

## 4. Mental Health & Substance History

**Have you <u>ever</u> been treated by a mental health professional?** ◯ YES ◯ NO

*If yes, for what condition(s)?*

_____

_____

**Which providers or mental health services have you used?** *(Check **<u>all</u>** that apply)*

☐ Psychiatrist ☐ Psychologist ☐ Social Worker ☐ Counselor ☐ Individual Therapy
☐ Group Therapy ☐ Support Group ☐ Other: _____

**Have you <u>ever</u> been hospitalized for mental health reasons?** ◯ YES ◯ NO

*If yes, please list dates, locations, and reasons:*

_____

_____

_____

**Substance Use History:**

**Have you <u>ever</u> sought treatment for alcohol or drug use?** ◯ YES ◯ NO

| Substance | Ever Used? | Age Range (Start / Stop) | Specific Type | Amount & Frequency |
|---|---|---|---|---|
| **Alcohol** | ◯ YES<br>◯ NO | Start Age _____<br>Stop Age _____ | | |
| **Recreational Drugs** *(e.g., cannabis, cocaine, opioids, hallucinogens)* | ◯ YES<br>◯ NO | Start Age _____<br>Stop Age _____ | | |
| **Tobacco Products** | ◯ YES<br>◯ NO | Start Age _____<br>Stop Age _____ | | |

## 5. Early Life & Cultural Background

**Developmental History:**

**Birth Status:** ◯ On time ◯ Premature ◯ Late

**Did you experience any medical problems at birth (e.g., low birth weight, immediate surgeries, NICU treatment)?** ◯ YES ◯ NO → *If yes, please describe:*

_____

**Did you experience delays learning to walk, talk, or toilet train?** ◯ YES ◯ NO

**Cultural & Language History:**

**Cultural or Ethnic Background:**_____

**Country of Birth:** _____

*If born outside the U.S., at what age did you immigrate?* _____

**City & State where you were primarily raised:** _____

**Languages Currently Spoken:** _____

**If multilingual:**

**What is your dominant language?** _____

**What language did you learn to speak first?** _____

**At what age did you begin learning a second language?** _____

**At what age did you become fluent in your second language?** _____

**Were you ever punished for speaking a particular language?** ◯ YES ◯ NO → *If yes, please explain:*

_____

## 6. Educational Background

**Did you earn a High School Diploma?** ◯ YES ◯ NO

*If yes:* **Year Graduated:** _____ **School Name:** _____

*If no:* **Last Grade Completed:** _____ **Do you have a GED?** ◯ YES ◯ NO

**Typical Grades / Estimated Cumulative GPA:** _____

**Did you attend college?** ◯ YES ◯ NO

*If yes:* **Number of Years Attended:** _____ **Name of College:** _____

**College Degree Earned?** ◯ YES ◯ NO

**Check all earned degrees & list majors:**

☐ **Associate's** (Major: _____)

☐ **Bachelor's** (Major: _____)

☐ **Master's** (Major: _____)

☐ **Doctorate** (Major: _____)

**School History (Childhood / Adolescence):**

**Did you repeat or skip any grades or classes?** ◯ YES ◯ NO → *If yes, please explain:*

_____

**Were you ever identified as "learning disabled" or placed in special education?** ◯ YES ◯ NO

*If yes, please explain:* _____

**Were you ever diagnosed with ADD / ADHD or labeled "hyperactive"?** ◯ YES ◯ NO

*If yes, please explain:* _____

**Did you experience any behavioral or disciplinary problems in school?** ◯ YES ◯ NO

*If yes, please explain:* _____

## 7. Military & Occupational History

**Military Service (If Applicable):**

**Branch of Military:** _____ **Service Dates:** _____

**Highest Rank Achieved:** _____ **Type of Discharge:** _____

**Military Occupation:** _____

**Did you serve in a combat zone?** ◯ YES ◯ NO

*If yes:* **Locations:** _____ **Dates:** _____

**Did you face any Article 15s or legal / disciplinary problems during service?** ◯ YES ◯ NO

**Employment History:**

**Are you currently working?** ◯ YES ◯ NO

*If yes:* **Occupation:** _____ **Hours per Week:** _____

*If no:* **Reason for Not Working:** _____

**Date Stopped Working:** _____

**What has been your primary job throughout your life?** _____

**Have you experienced any performance issues or problems in current or past jobs?** ◯ YES ◯ NO

**Have you ever been fired or suspended from a job?** ◯ YES ◯ NO → *If yes, why?*

_____

## 8. Financial, Legal, & Living Situation

**Disability & Benefits:**

**Do you currently receive disability benefits** ◯ YES ◯ NO → *If yes, specify:*

**Reason for Disability:** _____ **Date:** _____

**Have you ever been classified as disabled?** ◯ YES ◯ NO → *If yes, specify:*

**Reason for Disability:** _____ **Date:** _____

**Do you have a pending application for disability or VA service connection?** ◯ YES ◯ NO → *If yes:*

**With Whom (VA / SS)?** _____ **For What Condition(s)?** _____

**Legal History:**

**Have you ever had any civil or criminal legal problems?** ◯ YES ◯ NO

*If yes, please describe:* _____

**Current Living Situation:**

**Marital Status:** ☐ Single ☐ Married / Long-term Partner ☐ Separated ☐ Divorced ☐ Widowed

*Current Marriage Date:* _____ *Past Marriage Dates:* _____

**Do you have children?** ◯ YES ◯ NO → *If yes, list their ages:* _____

**Who currently lives in your home with you?** _____

**Do you have a legally appointed conservator or guardian?** ◯ YES ◯ NO

*If yes, name and date appointed:* _____

**Briefly describe your typical daily activities:**

_____

_____

**What level of assistance, help, or supervision do you require from others daily?**

_____

_____

## 9. Additional Questions or Concerns

*Please use this space to add any other information, questions, or concerns you would like to discuss:*

_____

_____

_____