

# Edelson & Associates, P.S.C.

NEUROPSYCHOLOGICAL, PSYCHOLOGICAL & FAMILY SERVICES

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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:

<i>Name</i>	<i>Relationship to Patient</i>	<i>Age</i>

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.*

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

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:**

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**Describe problems you are presently having:** \_\_\_\_\_

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**Are any of your family members reporting similar problems?** \_\_\_\_\_

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**When did problems begin?** \_\_\_\_\_

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**What have you done to try to solve/deal with problems?** \_\_\_\_\_

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**Additional information you think we should know:** \_\_\_\_\_

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