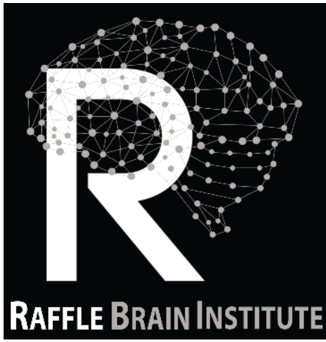

David L. Raffle, PhD, HSPP
Clinical and Forensic Neuropsychologist
Indiana License 20043200A

301 East Carmel Drive, Suite E100
Carmel, Indiana 46032
TF: (800) 450-9799 Fax: (317) 947-1614
info@rafflebraininstitute.com www.rafflebraininstitute.com

CLIENT HISTORY

Person completing this form: □Client □Spouse □Parent □Other ________________ Date: __________________

Client's Name: _____________________________________ Date of Birth____________________________

Handedness: □Left-handed □Right-handed □Both (Ambidextrous)

Height:_______________ Weight_______________ Recent Weight Gain? □ Weight Loss? □ Number of Pounds _________

Briefly explain the main concern or problem that brings you to Raffle Brain Institute, and/or the reason your doctor referred you for evaluation/therapy:
____
____
____
____
____

Medical History

Current Primary Physician: Name______________________________________ Phone___________________________

Family Medical History: Please indicate any family members who have received medical treatment:

Relationship Problem Type of Treatment
____
____
____

Mother had any difficulty during her pregnancy with you?

□No □Yes: Describe:____

Were you born prematurely or were there any complications at the time of your birth?

□No □Yes: Describe:____

Were there any problems with your development (walking, speaking) during childhood?

□No □Yes: Describe:____

Have you ever had?

Heart Disease	□No	□Yes	Date of Diagnosis: _____________________________________
High blood pressure	□No	□Yes	Date of Diagnosis: _____________________________________
Diabetes	□No	□Yes	Date of Diagnosis: _____________________________________
Parkinson's Disease	□No	□Yes	Date of Diagnosis: _____________________________________
Fibromyalgia	□No	□Yes	Date of Diagnosis: _____________________________________

Asthma	□No	□Yes	Date of Diagnosis: ___
Arthritis	□No	□Yes	Date of Diagnosis: ___
Anemia	□No	□Yes	Date of Diagnosis: ___
Chronic Fatigue Syndrome	□No	□Yes	Date of Diagnosis: ___
Brain Surgery	□No	□Yes	Date(s):___
Meningitis	□No	□Yes	Date(s):___
Encephalitis	□No	□Yes	Date(s):___
Cancer	□No	□Yes	Date(s):___
Cataract surgery	□No	□Yes	□Left □Right □Both Date(s): ___
Low blood pressure	□No	□Yes	Date(s):___
Heart Attack	□No	□Yes	Date(s):___
A fever of 104 or above	□No	□Yes	Date(s):___
Loss of consciousness / Coma	□No	□Yes	Date(s):___
CPR/Artificial Respiration	□No	□Yes	Date(s):___
Lead or Other Poisoning	□No	□Yes	Date(s):___
Stomach Problems/Ulcers	□No	□Yes	Date(s):___
Bowel Disease/Crohn's/Colitis	□No	□Yes	Date(s):___
Kidney/Urinary Problems	□No	□Yes	Date(s):___
Burns	□No	□Yes	Date(s):___
Allergies	□No	□Yes	Type(s)___
Broken Bones	□No	□Yes	Type(s)___

List All Surgeries (Emergency, Elective, & Cosmetic) and Dates___

___

Review of Current/Recent Symptoms

Which of the following neurological symptoms have you experienced in the past 12 months?

Memory Difficulties	□No	□Yes	Describe:___
Attention/Concentration Problems	□No	□Yes	Describe:___
Judgment/Problem-Solving	□No	□Yes	Describe:___
Word-Finding Difficulties	□No	□Yes	Describe:___
Speech Difficulties	□No	□Yes	Describe:___
Learning Problems	□No	□Yes	Describe:___
Chronic ringing in ears	□No	□Yes	Describe:___
Difficulty Speaking Clearly	□No	□Yes	Describe:___
Chronic Pain	□No	□Yes	Describe:___
Migraine Headaches	□No	□Yes	Describe:___
Dizziness	□No	□Yes	Describe:___
Tension Headaches	□No	□Yes	Describe:___
Frequent Falling	□No	□Yes	Describe:___
Tremors/Shakiness	□No	□Yes	Describe:___
Change in ability to smell	□No	□Yes	Describe:___
Hearing problems	□No	□Yes	□Left □Right □Both
Date of last hearing check:___			
Vision Problems	□No	□Yes	Describe:___
Do your glasses correct your visual difficulties? □No □Yes			
Date of last vision check:___			
Blurred/Double Vision	□No	□Yes	Describe:___
Temporomandibular Joint (TMJ)	□No	□Yes	Describe:___
Menstrual problems/PMS	□No	□Yes	Describe:___
Muscle jerks or twitches	□No	□Yes	Describe:___
Sleep Problems	□No	□Yes	Average Number of Hours of Sleep Each Night: ___
Difficulty Falling Asleep? □No □Yes Difficulty Staying Asleep? □No □Yes			
Do you dream? □No □Yes If yes, many nightmares? □No □Yes			
Sleep Apnea	□No	□Yes	Date of Diagnosis: ___
Sexual Function Problems	□No	□Yes	Describe:___

Medications

Current medication(s), Reason for taking, and Dosage (if known)

____
____
____
____
____
____

Medications stopped within the past three months, and reason for discontinuing:

____
____
____
____

Head Injury (Concussion, Traumatic Brain Injury):

Age at the time of the first head injury: ___________ Do you remember the actual event? □No □Yes

Describe the incident: ____

Did you lose consciousness? □No □Yes Length of unconsciousness: __________________________

What was your last clear memory before the injury? ____

What was your first clear memory after the injury? ____

Describe any medical treatment/medication you received in relation to the head injury:
____

List any physical symptoms you had following the head injury (such as vomiting, blurred vision, or headache):
____

How long did it take for you to get back to your "old self" after the head injury (if you have)?
____

Please describe any additional head injuries (dates, treatment, etc.)

____
____
____

Seizures/Epilepsy (Please complete this section if you have had seizures):

Age of first seizure: _____ When was your last seizure: __________

Describe the seizure: ____

Type of epilepsy diagnosed by doctor:____

Did you lose consciousness during the seizure? □No □Partially □Completely

Do you have an aura before the seizure? □No □Yes Describe: ____

How often do the seizures occur (number per days, week, or month)? ________________________________

Evaluation History

Have you ever had?

Educational Testing	□No	□Yes	Date or Age ______	Reason____
Psychological Testing	□No	□Yes	Date or Age ______	Reason____
Neuropsychological Testing	□No	□Yes	Date or Age ______	Reason____

Psychological History

Family Psychological History: Please indicate any family members who have received psychiatric treatment or treatment for drug or alcohol problems):

Relationship Problem Type of Treatment

____
____
____

Personal Psychological History: Please indicate your past or current psychological or psychiatric treatment, if any:

Name of Psychologist/Psychiatrist Years (start/finish) Reason/Diagnosis

____
____
____

Which of the following psychological symptoms have you experienced in the past 12 months?

Personality Changes	□No	□Yes	Describe:____
Decreased Happiness	□No	□Yes	Describe:____
Decreased Motivation	□No	□Yes	Describe:____
Violent Thoughts/Behaviors	□No	□Yes	Describe:____
Fatigue/No Energy	□No	□Yes	Describe:____
No Motivation/Interest	□No	□Yes	Describe:____
Social Isolation/Withdrawal	□No	□Yes	Describe:____
Frequent Anxiety/Worry	□No	□Yes	Describe:____
Nervousness/Tension	□No	□Yes	Describe:____
Depressed Mood	□No	□Yes	Describe:____
Anger and Hostility	□No	□Yes	Describe:____
Unusual Thoughts	□No	□Yes	Describe:____
Obsessions/Compulsions	□No	□Yes	Describe:____
Interpersonal Conflicts	□No	□Yes	Describe:____
Feelings of Paranoia	□No	□Yes	Describe:____
Grieving/Loss/Bereavement	□No	□Yes	Describe:____
Fears and Phobias	□No	□Yes	Describe:____
Nightmares	□No	□Yes	Describe:____
Flashbacks	□No	□Yes	Describe:____
Mood Changes (Up or Down)	□No	□Yes	Describe:____

Eating Problems □No □Yes: Overeating/Bingeing □No □Yes Undereating/Anorexia □No □Yes
Past Suicide Attempts □No □Yes Describe:____
Past or Current Suicidal Thoughts (Killing Yourself)? □No □Yes: □Past □Current
Past or Current Homicidal Thoughts (Killing Others) □No □Yes Describe:____
Hallucinations □No □Yes: □Visual (seeing) □Auditory (hearing) □Tactile (touching) □Olfactory (smelling)

If Yes, Describe Hallucination(s):____

Other Not Listed: ____

Financial/Legal History

Have you ever been convicted of a felony or misdemeanor? □No □Yes Describe:___________________________________

Have you ever been in jail? □No □Yes Describe: ____

Do you currently hold a driver's license? □No □Yes If yes, are you currently driving? □No □Yes

Have you ever been convicted of a DUI? □No □Yes Year _____ Punishment___________________________________

Are you currently involved in any legal proceedings? □No □Yes Describe:_____________________________________

Are you represented by attorney? □No □Yes Attorney's Name ____________________________________

Are you current involved in a Workers Compensation Case? □No □Yes Date of Injury______________

Applying/Applied for Disability? □No □Yes □Granted □Denied Date _________

Are you currently receiving any type of disability income? □No □Yes Disability_______________________________

Substance History

Have you ever drank alcohol? □No □Yes Year you first drank alcohol ______ Greatest number of drinks/week________

Do you currently drink alcohol? □No: Year Stopped_____________ □Yes: Current number of drinks per week________

Have you ever tried or taken the following drugs? Check all that apply, and circle specific drugs:

□Marijuana (Pot, Grass. Weed, Blunt, Dope, Joint, Hash, Hashish, THC, Reefer, Haze, K2, Spice, Cloud 9, Mojo)
□Cocaine (Coke, Crack, Rock, Powder, Flake, Snow, Snorting, Freebase, Speedball)
□Amphetamines (Speed, Crystal Meth, Crank, Dexedrine, Adderall, Ritalin, MDMA, Ecstasy, Molly, MDPV, Bath Salts, Flakka)
□Opiates (Heroin, Morphine, Opium, Codeine, Lortab, Fentanyl, Methadone, OxyContin, Demerol, Vicodin, Percocet, Opana)
□Hallucinogens (LSD, Acid, Mescaline, Ketamine, Mushrooms, STP, Salvia, Phencyclidine, PCP, Angel Dust)
□Inhalants (Glue, Paint Thinner, Gasoline, Freon, Toluene, Nitrous Oxide, Laughing Gas, Ethyl Chloride, Poppers, Amyl Nitrate)
□Benzodiazepines (Valium, Klonopin, Rohypnol, Ativan, Versed, Halcion, Librium, Xanax)
□Barbiturates (Downers, Phenobarbital, Amytal, Seconal, Nembutal, Luminal)
□Other Sedatives/Narcotics (Quaaludes, Placidyl, Chloral Hydrate, Miltown, GHB)

Other recreational, street drugs, or prescription drugs not listed:____

For all drugs listed, give age of first use, frequency, and age of last use of circled drugs:

Age of First Use Frequency (uses per day or week) Age of Last Use

____
____
____
____
____

Have you ever received treatment to help you stop taking drugs or abusing alcohol? □No □Yes

If Yes, give locations and dates:

____
____
____

[Arrests for drug use or possession or DUI should be listed in the Legal section above]

Have you ever smoked tobacco cigarettes? □No □Yes Year Started________ Year Stopped_______Packs/Day:________

Do you smoke a pipe? □ Cigar? □ Chewing Tobacco? □

Do you drink caffeinated beverages (e.g., coffee, tea, soda)? □No □Yes Number/Day__________

Social and Family History

Where were you born/raised?____

Language(s) of Household________________________ English was Primary (First) Language? □No □Yes

Mother's Name ____ Handedness: □Left □Right

Highest level of education: _____________ Occupation: ____

Father's Name ____ Handedness: □Left □Right

Highest level of education: _____________ Occupation: ____

Names and Ages of Brothers and Sisters:____

Places Where You Lived: Location:________________________________ Years: From ____________ To____________

Location:________________________________ Years: From ____________ To____________

Spouse/Partner's Name___________________________ Year Married______ Year Divorced?_____Year Widowed?______

Spouses' Highest level of education: _____________Occupation: ____

Children's Names and Ages:____

With whom do you currently live? (List all relationships)____

____

What are your hobbies, interests, or favorite activities? ____

____

What musical instruments do you play? ____

Current Religious Preference: _________________________Actively Involved? □No □Yes

What is your primary source of financial support?____

List those individuals whom you see as your primary source of emotional support:____________________________________

____

Educational History

Highest grade completed: _______ Graduated High School? □No □Yes GED?: □No □Yes

Average Grades on Report Card: Elementary ____ Middle School ____ High School ____ College ____

Skipped/Repeated any grades? □No □Yes (explain) ____

Special education classes, tutoring, or alternative school placement (if any): ______________________________________

Easiest subjects: ________________________________Difficult subjects: _______________________________________

College or University Name__________________________________ Location: ____________________________________

Degree: ________ Major/Area: ____

Technical or Vocational Training (if any): ____

Total Years of Education: ______

Employment History

Please describe your past jobs:

DATES WORKED JOB TITLE JOB DUTIES REASON FOR LEAVING

____

____

____

____

Are you currently employed?

□No How long? _________ Reason for unemployment: ______________________________

□Yes How long at your present job? __________ Company:__________________________ Self-Employed? □No □Yes

Job Title: ____________________________________

Job Description: ____

How did you sleep the night before this evaluation? ____

Is there anything we haven’t asked you about that you believe is important for us to know?

____

____

____

____

____