Mass General Brigham
Salem Hospital

Neuropsychology Service Adult Intake Form
Fax: 978.740.4960

Identifying Information:

Patient's Name:	Address::		
City:	State:	Zip Code:	Date of Birth
Primary Insurance:	Policy #:	Phone #:	
Secondary insurance (if applicable):	Policy #:	Phone#:	
Home Phone:	Work Phone:	Cell Phone:	

Who should be contacted to schedule the appointment? o Patient o Other

If Other:
Name: ____________________________ Phone #: _________________________________

Who referred you?

Name:	Phone Number:
o Self o PCP o Neurologist	o Psychiatrist o Therapist o Other ________________________________

Please provide the reason for your referral, including specific questions you would like addressed:

What language(s) does patient speak?_________________________________ **Interpreter Needed? Yes No**

Please indicate any areas which are currently problematic:

o Memory
o Attention
o Language
o Increased confusion
o Meeting school or work responsibilities
o Feeling depressed, anxious, or mood instability

School and Employment History

Please indicate highest level completed:
o Elementary School
o Some High School
o High School
o College
o Postgraduate

Have you ever repeated a grade?
☐ Yes ☐ No

Attention/ Learning issues:

Handedness:
☐ Right-handed ☐ Left-handed
☐ Ambidextrous/mixed

Previous testing (psychological, school, or neuropsychological):
☐ Yes ☐ No
**** Please send or bring copies of most recent evaluation reports to the appointment.**

Employment:
Currently employed? ☐ Yes ☐ No
If Yes, Employer: __________________________ Job Title or Description: _______________________
Duration of employment: ________

If not currently employed, have you been employed in the past?
☐ Yes ☐ No

Family History

	Psychiatric	Learning	Attention	Dementia	Substance Abuse
Parents					
Siblings					
Please describe:					

Psychiatric/Substance Use History

Have you ever had any of the following, or are you having any difficulties with the following items:	
☐ Depression	☐ Eating Disorder
☐ Anxiety	☐ Being afraid or having fearful thoughts
☐ Mood instability	☐ Insomnia
☐ Confusion	☐ Problems oversleeping
☐ Suicidal thoughts	☐ Addictions
☐ Frequent crying	

Substance use history

☐ Cigarettes (# of cigarettes/day: ___________) ☐ Other drugs ____

How many alcoholic beverages usually consumed in a week (1 drink = 1 oz hard liquor, 4 oz wine, or 8 oz beer):
☐ None ☐ 1-2 drinks/wk ☐ 3-4 drinks/wk ☐ 5-7 drinks/wk
☐ 8-10 drinks/wk ☐ 11 or more drinks/wk

Please describe:

Medical History

Please check if you currently or have had any of the following:		
☐ Transient Ischemic Attacks (TIA)	☐ Concussion/traumatic brain injury	☐ ADHD
☐ Stroke/CVA	☐ Multiple Sclerosis	☐ Learning Disability
☐ High Blood Pressure	☐ Cancer	☐ Other developmental delay
☐ Elevated Cholesterol	☐ Liver disease	☐ Vision problems
☐ Heart Attack	☐ Hepatitis	☐ Hearing problems
☐ Congestive Heart Failure	☐ Kidney disease	☐ Frequent falls
☐ COPD	☐ Headache	☐ Sleep problems
☐ Vascular Disease, other	☐ Diabetes	☐ Sleep apnea
☐ Seizures	☐ Lead Paint Poisoning	☐ Other

If yes, please elaborate:

Have you had any brain imaging performed (e.g., MRI, CT scan)? ☐ Yes ☐ No

Please list any current specialists (e.g., neurologist, psychiatrist, psychotherapist/counselor):		
Name of Professional	Specialty	Phone Number

______________________________ ______________________________
Name of Person Completing Form Relationship to Patient

______________________________ ______________
Signature Date