Kemper & Associates Neuropsychological Services

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Ph. 623-312-3713 * Fax 623-328-9352**

Background Information (for adults)

Name _____ **Age** _____ **Today's Date** _____
Social Security # _____ **Date of Birth** _____
Address _____ **City** _____ **Zip** _____
Home Phone (_____) _____ **Work Phone (_____)** _____
Other Phone (_____) _____ **where do you prefer to be called?** _____
Where may we leave a message? _____
In Case of an emergency please notify:
Name _____ **Phone (_____)** _____ **Relationship** _____
Never married _____ **living with someone since** _____ **Married since** _____ **Separated since** _____
Divorced since _____ **Widowed since** _____ **# times married** _____ **# children** _____
Son's age _____ **Daughter's ages** _____
Significant Other Name _____ **Age** _____ **Occupation** _____
Excluding yourself, who lives in your household?
_____
Why are you seeking evaluation? _____
Name & Phone # of your referring doctor for evaluation: _____
Will your evaluation be requested by anyone else besides your referring physician? _____
Will your evaluation be requested by an attorney or used for legal purposes? _____
Is there a history of this problem or a precipitating event? _____
Have you had a previous evaluation? _____ **If so, with who?**_____
What current social, family, spiritual, or other supports do you have? _____
_____
What coping strategies/hobbies do you have?_____
List current medications & prescribed by who:_____ _____
Allergies:_____
History of trauma or abuse (physical, sexual, or emotional) _____
_____
Educational Background (include highest level of education) _____
_____
Occupational Background (include jobs held for past 5 years) _____
_____
History of arrests, court proceedings or other legal issues which have you have been involved: _____
_____
Current or chronic health problems: _____
_____
Previous Counseling (including provider names, dates and place)
_____
_____
Previous Hospitalizations for emotional or substance abuse problem (include dates and places) _____
_____
History of medications for emotional/ substance abuse problems _____
_____
Have you had neuroimaging (MRI/CT/PET), EEG, or lab work done in the last year? _____
If so, list results: _____
Substance Use
(0= no use, 1=use, please list how much and how often, 2= addiction; 3= currently in treatment)
Alcohol _____ **Illicit drugs** _____ **Tobacco** _____ **Caffeine** _____
Past Use of Drugs (specify) _____ **When Last Used** _____