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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

Current Medical Problems:



Past 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 ever 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 ever had any of the following tests? (Check all that apply)

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

If yes, when and where?

Have you ever received Rehabilitation Services?

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

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



Do you currently 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 family history 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 ever 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 all that apply)

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

Have you ever been hospitalized for mental health reasons? ☐ YES ☐ NO

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



Substance Use History:

Have you ever sought treatment for alcohol or drug use? ☐ YES ☐ NO

Substance	Ever Used?	Age Range (Start / Stop)	Specific Type	Amount & Frequency
Alcohol	☐ YES ☐ NO	Start Age _____ Stop Age _____		
Recreational Drugs (e.g., cannabis, cocaine, opioids, hallucinogens)	☐ YES ☐ NO	Start Age _____ Stop Age _____		
Tobacco Products	☐ YES ☐ NO	Start Age _____ 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:
