

## North Penn Neuropsychological Services

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NIADAE (Deint)	DATE	DOP:
NAME (Print):	DATE:	DOR:

## SYMPTOMS CHECKLIST

Please let us know if you have been experiencing any of the following symptoms or have been diagnosed with any of the following:

SYMPTOM/ DIAGNOSIS		AST 6 THS?	EXPERIENCED IN THE PAST 18-24 MONTHS?		SYMPTOM/ DIAGNOSIS	THE F	EXPERIENCED IN THE PAST 6 MONTHS?		EXPERIENCED IN THE PAST 18-24 MONTHS?	
	YES	NO	YES	NO		YES	NO	YES	NO	
Anxiety					Memory Problems					
Autoimmune Disease					Mood Swings					
Blackouts					Nausea					
Blurred/Double Vision					Nervousness					
Burning Sensations					Nerve Pain					
Cardio-vascular Issues					Numbness					
Depression					Personality Changes					
Digestive Issues					Poor Balance/Coordination					
Difficulty Finding Words					Poor Concentration					
Disorientation					Ringing in The Ears					
Dizziness					Sadness					
Drowsiness/Fatigue					Seeing Stars					
Dry Mouth					Sensitivity to Cold/Heat					
Easily Distracted					Sensitivity to Light					
Feeling Like "In A Fog"					Sensitivity to Noise					
Feeling "Slowed Down"					Sleep Disturbances					
Hair Loss					Sleeping More Than Usual					
Headaches/Migraines					Tremors/Twitching					
Hearing Voices					Vacant Stares					
Hormonal Imbalance					Glassy Eyes					
Irritability					Vertigo					
Loss of Consciousness					Vomiting					
Loss of Orientation					Weakness					
Loss of Sense of Smell					Weight Gain/Loss					