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❖ ***Please answer all questions that apply to you. Your family or friends can help.***

Questionnaire completed by:_____ Date:_____

BACKGROUND INFORMATION

Name:_____

Age:_____ Date of Birth:_____ Place of birth:_____

Sex:_____ Marital Status:_____ Native language:_____

Ethnicity:_____

Handedness (circle one): Right Left

Did you ever change from using one hand to the other? (YES / NO)

Home address:_____

Phone: Daytime/Work:_____ Evening/Home phone:_____

Who referred you to our office? _____

Address:_____

Phone: _____

Have you ever had neuropsychological evaluation in the past (if YES, when?) _____

[PLEASE BRING copies of reports of all prior evaluation with you for your appointment.]

Have you had a recent CT or MRI scan <u>of the brain</u>? yes____ no____

[If possible, please bring actual films or CD (only the most recent ones), with you for your appointment.]

Does the purpose of your evaluation relate to current or potential legal action? yes____ no____

If yes, please describe_____

_____

_____

_____

_____

_____

_____

_____

_____

HISTORY OF CURRENT PROBLEMS:

What are the most important problems that prompted this evaluation?

1.
2.
3.

When did these problems start? _____

Are they still present? _____

Are they getting better, worse, or staying the same?_____

Please provide an example:_____

_____

_____

_____

_____

Other relevant problems:_____

_____

_____

_____

Do you currently drive? yes____ no____

If not, when did you stop driving?_____

Please circle the problems that you currently have or have had in the recent past.

headaches	eye problems	dry mouth
lightheadedness	blurry vision	problems urinating
fainting	double vision	urinary incontinence
dizziness	drooping of eyelid	bowel incontinence
weakness	hearing problems	diarrhea
numbness	tinnitus/ringing in ears	constipation
tingling	problems with smell	weight loss
tremor	unusual smells	weight gain
problems walking	problems tasting	visual hallucinations
poor balance	unusual tastes	auditory hallucinations
clumsiness	problems chewing/swallowing	pain (where? _____)
problems speaking	Other problems: _____	

MOOD: How would you describe your mood? (Examples include: "very good, average, a bit down, depressed at times, depressed for longer periods of time, very depressed, anxious, angry, irritable.")

_____

Do you tend to worry a lot?_____

How do you feel about yourself?_____

Do you feel capable of making decisions about things?_____

Do you feel unenthusiastic, or lacking in drive?_____

Do you find it difficult to get started on things?_____

PAST OR CURRENT MEDICAL CONDITIONS: (check any that may apply):

	High blood pressure		Irregular heart beats		Cancer		Toxin/chem. exposure
	Low blood pressure		Migraine headaches		HIV infection		Depression
	TIA		Diabetes		Arthritis		Anxiety
	Stroke		Fainting spells		Thyroid disease		Alcoholism
	High cholesterol		Head injury		Sleep apnea		Drug use
	Heart disease		Seizures		Vitamin deficiency		Radiation exposure
	Bypass surgery		Chronic pain		Insomnia		Neuropathy

List all other illnesses (or conditions for which you have taken medications):

Date	Medical problem	Medications

List any hospitalizations:

Date	Medical problem	Hospital/City

MEDICATIONS: **Please list your current medications or bring a list. Indicate the dose you are taking, how often, the reason and start date.**

Medication/Vitamins	Single dose	Frequency	Reason (what is the medication for?)	Start date

SUBSTANCE HISTORY:

Do you currently use tobacco? yes____ no____ If yes, how much? _____ pack/day Since: _____

If you previously used tobacco, when did you stop? _____

Do you drink alcohol? yes____ no____ If yes, on average, how much? _____

If you used alcohol in the past, when did you stop? _____ Were you ever a heavy drinker? yes____ no____

Have you ever used any illicit drugs? yes____ no____ If yes, which one(s)? _____ _____

FAMILY HISTORY: **Please indicate the age and health of your blood relatives, if known.**

Please note problems such as diabetes, memory problems, depression, etc…

	Alive?	Current Age OR Age at Death	Education (highest level completed)	Occupation	Health problems? (or cause of death if deceased)
Mother	Y/N				
Father	Y/N				
Brother(s)	Y/N				
	Y/N				
	Y/N				
Sister(s)	Y/N				
	Y/N				
	Y/N				

Children	Age	Health problems (if any)

<u>Other than stated above</u>, is there ANY history of any of the following conditions in your immediate or extended family?

PLEASE CIRCLE: Alzheimer's disease, vascular dementia, any other dementia, seizures, Parkinson's disease, Huntington's disease, multiple sclerosis, stroke, brain tumor, any other neurologic disease, schizophrenia, depression, anxiety or panic, alcoholism, drug addiction (including prescription pain medications), any other psychiatric problem.

DEVELOPMENTAL HISTORY:

Where were you born? _____ Where were you raised? _____

Were you born: on time_____ prematurely_____ late_____ not known_____

Were there any known problems associated with your birth?_____

As a child, did you have any of the following conditions?

	attention problems		head injury
	reading disability (dyslexia)		Other learning disability
	hyperactivity		developmental delay

EDUCATIONAL BACKGROUND: Please fill in the highest level you reached in school:

High school _____ th grade GED? Y/N College___years Name of college: _____

Major/minor:_____ Degree:_____ Year received:_____

Graduate School:_____years Degree(s):_____ Name of university_____

Best subject(s)/grades:_____Worst subject(s)/grades:_____

Did you fail any grades? (YES / NO) If so, which grades?_____
Did you skip any grades? (YES / NO) If so, which grades?_____
Did you attend any special education classes? _____

WORK HISTORY: If you are currently working, what is your occupation/job title?_____

What company/organization do you work for?_____

Have you had difficulty working because of problems with your thinking or mood? yes____ no____

If yes, please explain:_____

Please list jobs you held in the past (starting with the most recent)

Position	From (year) to (year):

If retired, at what age did you retire?_____

PERSONAL/SOCIAL HISTORY:

What do you like to do most in your free time? _____

Current marital status: Married____ Single_____ Divorced____ Widowed_____ Separated: ____

Years married to current spouse: _____ Number of times married: _____

Spouse's name:_____

Spouse's education:_____

Spouse's occupation:_____

Spouse's health problems:_____

Not married, but living with partner: yes_____ no_____

ADDDITIONAL INFORMATION:

Is there any important information that was not covered by the questions above? If so, let us know:

_____

_____

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire. The information you have given us will be very helpful in your evaluation.

*****PLEASE BE SURE TO BRING THIS AS WELL AS PERTINENT RECORDS WITH YOU WHEN YOU COME IN FOR YOUR APPOINTMENT*****

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