NEUROPSYCHOLOGY QUESTIONNAIRE

(Please fill this out prior to your appointment and bring it with you.)

Name: ______________________________ Date of appointment: ______________

Date of birth: ________________ Age: _____

Home address: ____________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Home phone: ___________ Cell phone: ____________ Work phone: _____________

Highest level of formal education completed: _________________________________

If employed, current occupation: _________________________________________

If not employed, former primary occupation: ________________________________

Name and address of referring doctor: _______________________________________
_____________________________________________________________________
_____________________________________________________________________

Primary reason for having this neuropsychological examination (e.g., types of cognitive problems, related medical condition or injury):
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Date of onset or diagnosis of primary condition: ____________________________

What are the main diagnostic tests and treatments you have had related this current problem or condition? Please provide locations and approximate dates.
MRI or CT scan of the brain: ______________________________________________
EEG: __________________________________________________________________
Prior neuropsychological, educational or personality testing: __________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Other tests, treatments: __________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Are you currently involved in any legal action? Please specify: _____________________________________________________________________
CURRENT PROBLEMS

INDEPENDENCE
Check any of the following daily activities you cannot do fully independently.
- Bathe
- Use toilet
- Get dressed
- Prepare food
- Walk in house
- House work
- Yard work
- Home repairs
- Grocery shop
- Use telephone
- Pay bills
- Bank account
- Take medicine
- Be home alone
- Drive a car

Describe any other activities for which you need assistance below.
_____________________________________________________________________
_____________________________________________________________________

COGNITIVE PROBLEMS
Please check all of the following that currently give you difficulty:

- Mental processes slowed down
- Trouble concentrating or easily distracted
- Difficulty doing math in your head
- Trouble thinking of words or the names of things you want to say
- Trouble remembering what to buy when you go shopping
- Forgetting peoples’ names
- Losing things
- Forgetting recent events or experiences
- Trouble recalling experiences or things you learned long ago
- Getting lost or difficulty using maps
- Trouble solving complex problems
- Disorganized
- Acting impulsively (without planning or anticipating consequence)
- Other: ______________________________________________________

Did these cognitive problems come on gradually or suddenly? ________________
When did you first become aware of them? _______________________________

What do you think caused them?
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Since they started, have they become worse, stayed the same or gotten better? 
_________________________________________________________________
_________________________________________________________________

What do these cognitive problems prevent you from doing that you used to do?
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

What have you done to help you cope with or overcome these cognitive limitations?
_________________________________________________________________
PSYCHOLOGICAL, EMOTIONAL AND INTERPERSONAL PROBLEMS
Please check all of the following that you have recently or currently experience:

___ Large or rapid fluctuations in mood
___ Anxious, fearful, nervous
___ Tense, high strung or have difficulty relaxing
___ Depressed mood
___ Tendency to be self-critical or perfectionistic
___ Embarrassed by your limitations
___ Feel like a burden on others
___ Life is hardly worth the struggle, feel like giving up
___ Often irritable or frustrated
___ Angry or have difficulty controlling temper
___ Have thoughts most people would consider to be strange or bizarre
___ Hallucinations - seeing, hearing, smelling or feeling things that weren’t there
___ Delusions - believing things that are very unlikely to be true
___ Difficulty trusting others
___ Obsessive repetition of thoughts that bother you
___ Compulsive repetition of behaviors that are not really necessary
___ Serious conflict between family members
___ Marital problems
___ Sexual difficulties
___ Suffering the effects of prior physical, sexual or emotional abuse
___ Other: ______________________________________________________

MEDICAL HISTORY

List any major illnesses you have had in the past by approximate date:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

List any major surgeries you have had in the past by approximate date:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

List any past psychological or psychiatric difficulties for which you have had treatment with approximate dates. List any medications you were given for these difficulties.
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

The following may affect or involve brain functioning. Please check any you have had:

___ Medical complications during your mother’s pregnancy or your birth
___ Late to start walking, talking or going to school
___ Learning disability in school (anytime from 1st – 12th grade)
__ Attention or behavior problems in school (anytime from 1st – 12th grade)
__ Loss of consciousness from a blow to or rapid movement of the head
__ Deprived of oxygen (suffocated, nearly drowned, medical complications)
__ Sleep apnea (stopping breathing in your sleep)
__ High blood pressure
__ High cholesterol
__ Heart problems (arrhythmia, heart attack, bypass surgery)
__ Stroke, or stroke symptoms which went away
__ Diabetes
__ Low thyroid
__ Seizure
__ Infection of the brain (encephalitis, meningitis, abscess, etc.)
__ Hydrocephalus (water on the brain, high intracranial pressure)
__ Diagnosed with cancer or a tumor anywhere in your body
__ Been a heavy drinker for an extended period of time (years)
  Current amount of alcohol consumed ___________ per day, week
__ Used recreational drugs for an extended period of time (months or years)
__ Exposed to toxic chemicals which might damage the nervous system
__ Other: ____________________________________________

Please check any of the following experienced by any of your close blood relatives.
__ Learning disability
__ Attention deficit disorder
__ Seizures/epilepsy
__ Neurological illness
__ Psychiatric problems
__ Alcohol or drug abuse
__ Dementia (reduced mental abilities late in life greater than expected from aging alone)

**SOCIAL HISTORY**
Place of birth: _______________ If not U.S.A., year moved here: _______
First language: _______________ If not English, years of formal English study: _____
Mother’s level of education: ____________ Occupation: __________________________
Father’s level of education: ____________ Occupation: __________________________
How many siblings do you have? Brothers: _____ Sisters: _____
How many of your siblings completed high school? _____ Attended college? _____
Did you have difficulty achieving academically in general or passing certain subjects?
________________________________________________________________________

Did you have special education, extra help or tutoring for reading, spelling, math or other subjects in school?
________________________________________________________________________

Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12
Typical academic grades last few years of school: A’s  B’s  C’s  D’s  F’s
Trade school or technical training: ____________________________________________
College or university attended: _____________________________________________
College major: __________________ GPA: ____ Degree: _____ Year: ______
Graduate degree(s): ________________________________________________________
OCCUPATION

Major types of employment you have had:
_____________________________________________________________________

Current or most recent job title: ___________________________________________

Major duties in above job: _____________________________________________

If retired or out of work, for how long? _______________________________

Reason for retirement: _______________________________________________

Current hobbies, interests, spare time activities: __________________________

MARRIAGE & HOME LIFE

Are you currently married? ____ How many years? ____ Number prior marriages ____

Widowed or widower? ____ How many years? ____ Divorced? ____ How many years? ____

Spouse’s occupation: __________________________________________________

Spouse’s health: _____________________________________________________

Children: Sex Age Highest level of education Occupation

M  F ___ ___________________ _________________________
M  F ___ ___________________ _________________________
M  F ___ ___________________ _________________________
M  F ___ ___________________ _________________________

Who currently lives with you in your residence? ___________________________

How do you typically spend most of your time each day? What activities do you usually engage in?
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

List any major changes you expect in your life in the near future: _______________
___________________________________________________________________________

ANSWER THE FOLLOWING ON THE DAY OF YOUR APPOINTMENT

How many hours of sleep did you get last night? _______

How is your mental energy today? ________________________________

How is your mood today? _________________________________________

Are you nervous or bothered by anything that may distract your attention? ___________

Do you have body pain or headache today? ______________________________

Did you ingest any alcohol or recreational drugs in the past 48 hours? ____________

List all of your present medications and indicate what each is for:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Any recent change in your medications? ________________________________

THANK YOU FOR YOUR ASSISTANCE