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