NEUROPSYCHOLOGICAL QUESTIONNAIRE

Please fill out this questionnaire completely and thoroughly. **Please do not leave any items blank**. If there is any part of this questionnaire that you do not understand, please let your Neuropsychologist know. Thank you for your cooperation.

DATE: ______________________________

IDENTIFYING INFORMATION

- Full Name: ______________________________
- Medical Record #: ______________________________
- Birthdate: ______________________________
- Gender: ______________________________
- Age: ______________________________

CONTACT INFORMATION

- Address: ______________________________
- Home Phone: ______________________________
- Work Phone: ______________________________
- Cell Phone: ______________________________
- Name and phone of emergency contact:______________________________
- Relationship to you: ______________________________

OTHER IMPORTANT INFORMATION

- Are you right-handed or left-handed? (Circle one) *Right* *Left*
- Is English your first language? (Circle one) *Yes* *No*
- If not, what is your first language? ______________________________
- Do you consider yourself fluent in English? (Circle one) *Yes* *No*
- What is your understanding of the reason for this evaluation?

____

- What questions do you hope to have answered by this evaluation?

____

- Has anyone assisted you with this form?______________________________
- If yes, whom? What is their relationship to you? ______________________________
- Are you involved in any **litigation or a lawsuit**? (Circle one). *Yes* *No*
- If yes, please explain: ______________________________

DEVELOPMENTAL HISTORY

- What was your weight at birth? ______________________________
- Did your mother have complications during pregnancy or birth? (Circle) *Yes* *No*
- Did your mother smoke cigarettes, use alcohol, or any drugs (including prescription medications) while pregnant with you? (Circle one) *Yes* *No*
- At what age did you begin walking? ______________________________
- At what age did you begin talking? ______________________________
- At what age did you begin reading? ______________________________
- Did you have any speech difficulties? (Circle one) *Yes* *No*
- Were you ever told you had a learning disability? (Circle one) *Yes* *No*
- Have you ever been referred for academic, psychological, or neuropsychological testing OR had your IQ tested? (Circle one) *Yes* *No*
- Were you ever referred for special education or gifted courses? (Circle one) *Yes* *No*
- Did you ever repeat or fail a grade? (Circle one) *Yes* *No*
- Did you have any problems with socializing? (Circle one) *Yes* *No*
- Grades in high school. (Please circle.)

  A *B* *C* *D* *F*
- Did you graduate from high school? (Circle one) *Yes* *No* GPA: ______________
- Year of graduation: ______________________________
- If you did not graduate from high school, why not? ______________________________

COLLEGES/UNIVERSITIES ATTENDED	Major	GPA	Degree Received

PERSONAL HISTORY

- Where were you born? ______________________________
- Where were you raised? ______________________________
- Father's profession ______________________________
- Mother's profession ______________________________
- Siblings (how many and their ages) ______________________________
- What is your ethnic/cultural background? ______________________________
- What is your religious or spiritual orientation? ______________________________

. . . .

- What is your relationship status? (Circle One)
- *Divorced* *Partnered* *Separated* *Single* *Widowed*
- Children (how many and their ages) ______________________________
- Occupation (if retired, state previous occupation and date of retirement)

  ____
- Employer: ______________________________
- Have you ever been in the military? (Circle one) *Yes* *No*

. . . .

- Were you ever the victim of sexual, physical, verbal, or emotional abuse? (Circle) *Yes* *No*
- Have you ever witnessed any domestic violence? (Circle one) *Yes* *No*
- Have you ever assaulted anyone? (Circle one) *Yes* *No*

If yes, please explain. ______________________________

- Have you ever been arrested? (Circle one) *Yes* *No*

If yes, please explain: ______________________________

SYMPTOM HISTORY	
Do you have any problems with the following? (If yes, please describe below.)	**How long have you had these problems?** (e.g., one year, 5 years, 10 years, 20 years, all my life)
Problem solving or organization?	
Memory?	
Attention?	
Speaking ability? (word finding, naming, comprehension)	
Arithmetic ability?	
Sense of direction? Getting lost? Judging heights, depth, or distance?	
Personality changes?	

Do you have any problems with the following?	**NO**	**YES**	**How long have you had these problems? (**e.g.**,** one year, 5 years, 10 years, 20 years, all my life)
Easily distracted			
Excessive daydreaming			
Losing your train of thought			
Getting stuck on certain ideas			
Getting lost in familiar places			
Forgetting childhood events after the age of 6			
Not recognizing important people in your life			
Not understanding what people say to you			
Not being able to express yourself in words			
Not able to think of the word you want			
Difficulty with organizing or prioritizing			
Beginning lots of tasks and not finishing them			
Acting first, thinking later (impulsivity)			
Run up a credit card debt or do dangerous things for fun			
Trouble controlling your temper			
Forgetting conversations, movies, books			
Forgetting to attend appointments			
Forgetting to take your medication			
Having any unusual touch, taste, smell, hearing or vision			

Do you have any problems with the following?					
Symptoms	**Now**	**In Past**	**Symptoms**	**Now**	**In Past**
Tension headache			Uncontrollable movements		
Migraine headache			Tremors		
Blurred vision			Muscle tics/twitches		
Double vision			Muscle weakness		
Vision blackouts			Muscular paralysis		
Ringing in the ears			Poor coordination		
Lightheadedness			Falling spells		
Poor balance			Low back pain		
Dizziness/vertigo			Numbness/tingling		
Fainting spells			Smelling		
Convulsions/seizures			Tasting		
Blackouts			Swallowing		

Do you have any difficulties with the following?					
Symptoms	**Now**	**In Past**	**Symptoms**	**Now**	**In Past**
Speaking			Recurrent fears		
Reading			Anxiety		
Writing			Chronic worry		
Memory for new info			Worry about health		
Old Memory			Panic attacks		
Understanding			Hyperventilation		
Thinking clearly			Irritability		
Concentration			Moodiness		
Periods of confusion			Feeling stress		
Chronic fatigue			Unable to relax		
Energy level			Nervous breakdown		
Loss of interest			Overreact emotionally		
Excessive drowsiness			Explosive temper		
Trouble sleeping			Change in personality		
Appetite			Feeling persecuted		
Feeling depressed			Hearing voices		
Hopelessness			Hallucinations		
Frequent crying			Drug use		
Thoughts of suicide			Heavy alcohol use		
Suicide attempts					

MEDICAL HISTORY

Has a doctor ever told you that you have:	**Yes**	**No**	**If yes, have you or are you being treated? Give details.**
Diabetes			
High blood pressure			
High cholesterol			
Heart disease (heart attack, strokes)			
Sleep apnea			
Thyroid disturbance			
Cirrhosis of the liver			
Hepatitis			What type?
HIV/AIDS			

Other current medical problems (including serious or chronic medical conditions)	**Date(s) of Diagnosis or Occurrence**	**Treatment**	**Details/Is the issue being addressed?**

Past medical problems, surgeries, and hospitalizations	**Date(s) of Diagnosis or Occurrence**	**Treatment**	**Details/Was the issue resolved?**

Please answer the questions below.	**Yes**	**No**	**<u>If yes, please gives details and dates.</u>**
Have you ever had a serious medical accident or injury?			
Have you ever had an injury to your head (e.g. motorcycle accident, car accident, sports injury, falls)?			Last thing you remember before injury: Last thing you remember after injury:
Have you ever lost consciousness?			
Have you ever been in a rehabilitation program for a head injury?			
Have you ever had brain surgery?			
Have you ever had a seizure?			
Have you ever seen a neurologist? *If so, please list all neurologists seen.*			
Have you ever been diagnosed with a neurological disease (e.g. meningitis, Parkinson’s, etc)?			
Have you ever had an MRI, CT Scan, SPECT, or PET Scan?			
Have you ever had bypass surgery?			
Have you ever had radiation or chemotherapy?			
Are you on disability? Or have you ever been on disability?			
Are you able to work?			

Please answer the following questions below.	**Yes**	**No**
Do you wear or need glasses to correct your vision?		
Do you wear or need a hearing aid?		

List all the medications you take, including vitamins, hormones, and non-prescription drugs.	**Dose**	**How Often?**

Do any of your biological relatives have:	**Yes**	**No**	**If yes, whom?**
Diabetes?			
High blood pressure?			
High cholesterol?			
Heart disease (heart attacks, strokes)?			
Epilepsy or seizures?			
Neuromuscular disease?			
Huntington’s or Parkinson’s disease?			
Dementia?			
Other diseases or conditions?			

PSYCHIATRIC HISTORY					
Have you ever:	**Yes**	**No**	**For what reason?**	**Provider/Place**	**Year**
Had counseling or psychotherapy?					
Seen a psychiatrist?					
Been psychiatrically hospitalized?					

Have you had difficulties with the following?	**Yes**	**No**	**If yes, please describe.**
Depression			
Anxiety			
Feeling that people are out to get you or scheming against you?			
Hearing voices			
Feeling or seeing things others didn't			
Having ideas that other people think are odd			
Suicidal thoughts			
Suicide attempts			
Thoughts of harming others			
Attempts to harm others			

List all past and current psychiatric medications.	**Yes**	**No**	**For what reason?**	**Year(s)**

Have any of your biological relatives had difficulties with	**Yes**	**No**	**<u>If yes, whom?</u>**
Depression			
Anxiety			
Attention deficit disorder			
Learning disabilities			
Schizophrenia			
Bipolar (manic depressive)			
Paranoia			
Hearing voices			
Feeling or seeing things others didn't			
Odd beliefs			
Suicide attempts			

SUBSTANCE USE					
Please answer the following questions.	**Yes**	**No**	**Drinks per day?**	**Drinks per week?**	**Last time you drank?**
How much alcohol do you drink?					
Have you ever drunk alcohol excessively?			If yes, please explain.		
Have you ever gotten a DUI?			If yes, please explain (give dates).		
Have you had any other legal problems associated with alcohol or drug use?			If yes, please explain (give dates).		

What is your experience of use with:	**Yes**	**No**	**Frequency of use**	**Last time you used this substance**
Nicotine/Tobacco products				
Marijuana				
Ecstasy				
Psilocybin (mushrooms)				
LSD				
PCP				
Cocaine				
Methamphetamines/amphetamines				
Heroin				
Methadone				
Ketamine ("special K")				
GHB				
Prescription medications				

Please answer the following questions.	**Yes**	**No**	**Drinks per day?**	**Drinks per week?**
Do you currently consume caffeine (sodas, tea, coffee, chocolate)?				

Have any of your biological relatives used substances excessively such as	**Yes**	**No**	**If yes, whom?**
Alcohol			
Drugs			
Nicotine			