

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