Elliot Memory & Mobility Center
Preserving Independence

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NEUROPSYCHOLOGICAL HISTORY QUESTIONNAIRE
Confidential

Patient's Name:_____

[Completed By: _____ Relationship to Patient: _____]

Today's Date: _____

Patient's Date of Birth: Current Age: ____

Gender: ☐ Female ☐ Male

Handedness: ☐ Right ☐ Left ☐ Both

Marital Status: ☐ Never married ☐ Married once ☐ Divorced
☐ Divorced, remarried ☐ Widowed ☐ Widowed, remarried

Ethnicity: ☐ African-American ☐ Hispanic ☐ Caucasian
☐ Native American ☐ Asian ☐ Other: _____

Address: _____ Day Phone: _____

_____ Evening Phone: _____

Referral Information

Person who referred you for testing: _____

Address: _____

Phone: _____

Fax: _____

What is your understanding of why you are undergoing this evaluation? Include all pertinent facts, such as date of injury/illness, what happened, etc.:

_____

_____

_____

_____

_____

Have you ever had any psychological or neuropsychological testing done before?

☐ Yes ☐ No

If Yes, by whom: _____

Date(s): _____

Test(s): _____

_____

Outcome: _____

_____

Is this case involved in any litigation currently, or do you intend to pursue litigation in the future?

☐ Yes ☐ No

If Yes, please describe: _____

_____

_____

_____

Presenting Problems/Symptoms

Please describe what symptoms or problems are of most concern to you:

_____

_____

_____

_____

Please describe when and how you first became aware of these difficulties and whether they have gotten worse over time:

_____

_____

Current Symptom Checklist

Please check each of the following symptoms or problems that you are experiencing. For each symptom that you check, please briefly describe it (for example, intensity, how long you have experienced it and how frequent it is):

	Describe
☐ Headaches	
☐ Dizziness	
☐ Coordination problems	
☐ Balance problems	
☐ Tremors or shakiness	
☐ Concentration problems	
☐ Visual problems	
☐ Hearing difficulties	
☐ Loss of feeling, tingling, or numbness	
☐ Difficulty pronouncing words clearly	
☐ Getting tired easily	
☐ Sensitivity to noise	
☐ Sensitivity to light	
☐ Pain	
☐ Difficulty remembering the right word	
☐ Being easily distractible	
☐ Poor concentration for extended periods of time	
☐ Difficulty reading or writing	
☐ Difficulty thinking clearly and efficiently	
☐ Difficulty planning and organizing things	
☐ Difficulty following through or finishing things	
☐ Personality changes	
☐ Apathy, lack of interest in things	
☐ Lack of initiative, don't start things up	
☐ Black-out spells	
☐ Irritability	
☐ Restlessness	
☐ Temper outbursts	
☐ Mood swings, quick emotional shifts	
☐ Getting bored easily	
☐ Getting lost	

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... **Symptom Checklist** continued

	Describe
☐ Anxiety/tension	
☐ Troubling thoughts that are difficult to keep out of mind	
☐ Depression	
☐ Loneliness	
☐ Loss of confidence	
☐ Feelings of guilt	
☐ Changes in appetite	
☐ Nightmares	
☐ Difficulty telling right from left	
☐ Forgetting meetings and appointments	
☐ Forgetting conversations and people's names	
☐ Forgetting the date and time	
☐ Forgetting to pay bills	
☐ Increased suspiciousness of others	
☐ Feeling slowed down	
☐ Sleep disturbance; change in sleep pattern	
☐ Decreased sexual drive	
☐ Increased sexual drive	
☐ Hallucinations	
☐ Other:	

Please list and describe any current sources of stress in your life (for example, any losses, major changes of circumstances, financial/interpersonal/job pressures, etc.):

Medical History

Please list all illnesses, surgeries, and hospitalizations that you have experienced:

Illness/Condition	Dates	Treatment

Have you ever experienced a head injury with loss of consciousness or sense of being "dazed"?

☐ Yes ☐ No

If yes, please describe:

Type of Head Injury	Date	Loss of Consciousness?	Outcome

Please list any neurological tests such as MRI, CT, spinal tap, or EEG, including dates and hospitals:

Test (Hospital)	Dates	Results

Please check any of the following that you have ever experienced, and briefly describe (for example, dates, frequency):

☐ Seizures _____
☐ Loss of sensation in any part of body _____
☐ Paralysis or weakness in any part of body _____
☐ Loss or change in sense of smell _____
☐ Loss of hearing _____
☐ Loss of vision _____
☐ Change in sense of taste _____
☐ Fainting spells _____
☐ High blood pressure _____
☐ Electric shock _____
☐ Exposure to toxic chemicals _____
☐ Hallucinations _____

Please list your current medications:

Medication	Amount	Reason

Please list any known allergies: _____

_____

_____

Do you now or have you ever regularly used tobacco products? ☐ Yes ☐ No

If Yes, please describe: _____

_____

_____

Do you now drink or did you ever regularly drink alcohol products? ☐ Yes _____ ☐ No

If Yes, please describe (what, amount, frequency): _____

_____

If no longer drinking, what is the reason that you stopped?

_____

In your opinion, is your drinking a problem? ☐ Yes ☐ No ☐ Not Sure

Have others ever told you your drinking is a problem? ☐ Yes ☐ No

Have you ever had legal difficulties related to drinking? ☐ Yes ☐ No

If Yes, please describe: _____

_____

Have you ever had work difficulties related to drinking? ☐ Yes ☐ No

If Yes, please describe: _____

_____

Have you ever been treated for alcohol abuse? ☐ Yes ☐ No

If Yes, please describe: _____

_____

Do you now use or have you ever regularly used illicit or "street" drugs (for example: marijuana, cocaine, heroin, LSD, etc.)? ☐ Yes ☐ No

If Yes, please describe (which, frequency):_____

_____

_____

Have you ever been treated for drug abuse? ☐ Yes ☐ No

If Yes, please describe:

_____

_____

Please indicate if anyone in your family has had the following conditions by checking the box and putting their relationship to you in the space provided:

☐ Diabetes	_____
☐ Hypertension	_____
☐ Heart Disease	_____
☐ Stroke	_____
☐ Cancer	_____
☐ Epilepsy	_____
☐ Multiple Sclerosis	_____
☐ Parkinson's	_____
☐ Alzheimer's	_____
☐ Alcoholism	_____

Please describe any other relevant family medical history:

_____

_____

_____

_____

_____

Please list any members of your family who are <u>left-handed</u>:

_____

_____

_____

Psychiatric History

Please describe your psychiatric history from the time of your first symptom to the present:

_____

_____

_____

_____

_____

Please provide names and dates of all psychiatric/psychological treatment and any hospitalizations:

Clinical or Hospital	Dates	Problem and Treatment

Please indicate if anyone in your family has had the following by checking the box and putting their relationship to you in the space provided:

☐ Depression _____
☐ Schizophrenia _____
☐ Anxiety _____
☐ Attention-Deficit Disorder _____
☐ Bipolar (Manic-Depressive) _____
☐ Other _____

_____

_____

Please describe any other family history of psychiatric problems:

_____

_____

_____

_____

_____

Developmental History

Did your mother ever smoke, take drugs, or use alcohol during pregnancy? ☐ Yes ☐ No
If Yes, please describe:

_____

_____

Were there any problems during the pregnancy or delivery? ☐ Yes ☐ No
If Yes, please describe:

_____

_____

Please check each of the following conditions that describe behaviors or emotions that you experienced as a *child*, and briefly describe:

☐ Delay learning to walk _____
☐ Delay learning to talk _____
☐ Delay learning to read _____
☐ Behavioral problems at home _____
☐ Behavioral problems at school _____
☐ Bedwetting _____
☐ Nail-biting _____
☐ Difficulty paying attention _____
☐ Memory problems _____
☐ Depressed _____
☐ Aggressive _____
☐ Shy _____
☐ Tantrums _____
☐ Nightmares _____
☐ Poor self-esteem _____
☐ Unpredictable _____
☐ Cried easily and often _____
☐ Speech or language problems _____

☐ Acted young for age _____
☐ Frustrated easily _____
☐ Excitable _____
☐ Stubborn _____
☐ Poor coordination _____
☐ Hyperactive _____
☐ Blank or staring spells _____
☐ Difficulty making friends _____
☐ Impulsivity _____
☐ Disorganized _____
☐ Difficulty controlling emotions _____
☐ Daydream often _____
☐ Easily distracted _____
☐ Trouble sitting still _____
☐ Difficulty finishing projects _____
☐ Attention wanders _____
☐ Fidgety _____
☐ Alcohol/drug use _____

Additional information about any childhood problems:

_____

_____

_____

_____

_____

_____

Educational History

Please summarize your educational history below:

School Attended	City, State	Dates	Grades or Degree Completed	Course of Study	Your Average Grades

Is English your primary language? ☐ Yes ☐ No

If No, list all languages spoken in order of fluency: _____

_____

Did you have difficulty with any school subjects? ☐ Yes ☐ No

If Yes, list which ones: _____

_____

_____

Did you ever have any special tutoring or counseling? ☐ Yes ☐ No

If Yes, explain: _____

_____

_____

_____

Did you ever repeat any grades? ☐ Yes ☐ No

If Yes, list which ones: _____

_____

_____

Were you ever placed in special classes in school? ☐ Yes ☐ No

If Yes, explain: _____

_____

_____

If you have ever taken standardized academic tests such as SAT, ACT, or GRE, please list the tests and your approximate scores:

Test	Date	Scores

Social History

Do you live alone? ☐ Yes ☐ No

If No, please describe your current living arrangement: _____

_____

_____

Where were you born? _____

Please list all of members of your family of origin (that is, your parents & siblings):

Name	Age	Relationship to you	Current Health	How is your relationship with him/her?

If applicable, please list all of members of your current immediate family (spouse & children):

Name	Age	Relationship to you	Current Health	How is your relationship with him/her?

Your current occupational status:

☐ Full-time ☐ Part-time ☐ Unemployed
☐ Retired ☐ Disability ☐ Volunteer

If currently employed, please list your job title and describe the type of work you do, including your responsibilities and the nature of the work. Be as explicit as possible:

_____

_____

_____

_____

Please summarize your occupational history below:

Position	Place	Dates	Reason for Leaving

Have you ever been on unemployment, disability, or workman's compensation? ☐ Yes ☐ No
If Yes, explain (include dates and reason for the claim): _____

_____

_____

Please list any special talents, interests, or hobbies: _____

_____

_____

Have you had any arrests or legal problems? ☐ Yes ☐ No
If Yes, explain (include dates and nature of the violations): _____

_____

_____

Please check any of the following activities of daily living that you cannot now do or have difficulty completing independently, and briefly describe:

- ☐ Getting dressed _____
- ☐ Bathing or showering _____
- ☐ Taking medication _____
- ☐ Cooking _____
- ☐ Cleaning _____
- ☐ Driving _____
- ☐ Managing finances _____
- ☐ Keeping appointments _____
- ☐ Shopping _____
- ☐ Other _____

Please add any additional information that you feel may be useful:

_____

_____

_____