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ADULT NEUROPSYCHOLOGY QUESTIONNAIRE

Name: _____ SSN: _____ DOB: ___/___/___ Age: _____

What is the problem that brings you here?

What questions do you want the assessment to answer?

SOCIAL HISTORY:

Where were you born? _____ Where were you raised? _____

Who raised you? _____ How many brothers and sisters did you have? _____

Times Married ___ Status Now: NM/Single Marr Div Widowed/er For How Long?_____

Do you have any children? ❑ Yes ❑ No If so, list their ages: _____

List any Neurological disease(s) in your family:

List any Psychiatric disease(s) in your family:

Who do you spend most of your time with?

EDUCATIONAL HISTORY:

Did you ever fail or repeat a grade?Yes No If Yes, Please explain: _____

List any "Special Education" classes (include year and school): _____

Did you have a Learning Disability? ____ If yes, what type or problem area?_____

Were you ever called Hyperactive? __ or Attention Deficit?: __ Where & When? _____

Did you take Ritalin to help you in school? _____ Other medicines (list)? _____

Check the following if they applied to you in school:

❑ Could not still	❑. Could not organize / finish work	❑. Always "on the go"
❑. "Fidgety" and restless	❑. Needed a lot of supervision	❑. Acted before thinking
❑. Could not stay seated	❑. Had trouble paying attention	❑ Got in a lot of trouble
❑. Destroying property	❑. Speaking out of turn	❑.Fighting
❑. Was a bully	❑. Used drugs or alcohol	❑. A "slow learner"

❑. Counseled a lot by principals, teachers, etc.

Were you on the Honor Roll or Dean's List? _____Never _____Rarely _____Usually _____Always

Years of education: _____ Typical grades _____

If you left school before graduation, what was the reason? _____

If you attended college: Highest degree awarded _____ Year _____ School _____

Major subject_____ Minor subject _____ GPA _____

Future educational plans:

OCCUPATIONAL HISTORY:

Currently employed? ____ Occupation? _____ Start Date: _____

If not working now, how long has it been since you worked? _____

If you are not working now, how long did you hold your last job? _____

What were your major responsibilities on the most recent job? _____

What has been your main type of work through the years? _____

List any problems in your current or past work:_____

Do you have an application for disability pending? ❑ VA ❑ Social Security ❑ Private Insurance

What disability are you claiming?

Military service? Yes No Branch: _____Service Dates: _____ Rank _____ MOS_____

What are your future occupational plans?

MEDICAL HISTORY

Were there any complications or problems with your mother's pregnancy and delivery?

Were you a full-term baby? _____ If not, how premature?_____ Your birth weight? _____

Please give your best guess of the age you walked _____ and talked _____

Have you ever had a significant head injury? ❑ Yes ❑ No

If yes, please describe injury, when, whether unconscious, and if so, how long?

Injury	When	Unconscious?	If so, how long?

Please check any of the following that you have ever had

❑ Coma	❑ Kidney disease	❑ Infections (type: _____
❑ Diabetes	❑ Liver disease	❑ Multiple Sclerosis
❑ Hypoglycemia	❑ Encephalitis	❑ Hypertension
❑ Seizures	❑ Arteriosclerosis	❑ Tumor/Cancer
❑ Meningitis	❑ Venereal disease	❑ Brain abscess (or aneurysm)
❑ Stroke	❑ Heart disease	❑ Thyroid problems
❑ Sun Stroke	❑ Delirium	❑ Amnesia/Memory
❑ Dementia	❑ Other (please list): _____	

Please check any of the following that you have ever experienced or been exposed to:

❑ Lead (in paint, etc) ❑ Toxic chemicals ❑ Electrical shock
❑ Carbon Monoxide ❑ Malnutrition ❑ Chemical accidents
❑ Industrial solvents ❑ Overcome by gas ❑ Lack of oxygen
❑ Partial drowning ❑ Other environmental trauma:

Have you ever been seen by a Psychiatrist/Psychologist? Yes No.

If so, please explain when and why:

Have you ever attempted suicide? ❑ No ❑ Yes

Please check any of the following that you have experienced recently:

❑ Impulsivity (act before thinking) ❑ Getting lost ❑ Periods of confusion
❑ Severe headaches ❑ Nausea or vomiting ❑ Temper outbursts
❑ Memory problems ❑ More easily frustrated ❑ Shaking or tremor
❑ Personality changes ❑ Change in smell or taste ❑ Walking differently
❑ Loss of interest ❑ Inability paying attention ❑ Dizziness
❑ Hallucinations ❑ Problems with judgment ❑ Blank spells
❑ Difficulty doing things you used to do well ❑ Ringing in ears ❑ Fainting
❑ Visual changes ❑ Loss of coordination
❑ Unusual weakness ❑ Hearing changes ❑ Numbness in the body
❑ Loss of bladder / bowel control ❑ Loss of ability to have sex
❑ Burning/tingling in the body ❑ Uncontrollable laughing or crying
❑ Other: _____

Do you have arthritis or injuries in your shoulders, arms, or hands that would affect your feeling, strength, or speed in your limbs? Yes No Where?_____

Do you have a hearing loss? _____

Have you been told that you have a vision problem that requires glasses? _____

List ALL medicines you currently take, both prescribed and "over the counter":

Drug	Dosage	When Started?	Side effects?

(use other side if necessary)

Current level of alcohol use:

Were you ever a heavy drinker in the past? Yes No

How much coffee do you drink? _____

Please list any other non-prescribed chemicals or drugs that you have abused now or in the past

Have you ever participated in any substance abuse treatment program? Yes No

If so, please describe:

What language(s) do you use/speak most of the time?_____

What language(s) did you learn <u>first</u> as a child?_____

2nd Language?_____

If there is anything about your current functioning or about your past experiences that you think would be helpful to us, please write it here: