ADULT NEUROPSYCHOLOGY
HISTORY QUESTIONNAIRE

DEPARTMENT OF NEUROLOGY
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Medical Center Clinic
HEALTHCARE CENTERED AROUND YOU

NAME: _____ DATE: _____
SSN: _____ DATE OF BIRTH: _____
ADDRESS: _____ HANDEDNESS (circle one):
_____ Right Left Ambidextrous
_____ EDUCATION: _____years
TELEPHONE: _____ OCCUPATION: _____
REFERRAL SOURCE: _____ ETHNICITY: _____

MARITAL STATUS (circle one): Single Married
Separated Divorced Remarried Widowed

THIS FORM WAS COMPLETED IN WHOLE, OR IN PART, BY:

_____ _____
RELATIONSHIP TO PATIENT

PRESENTING PROBLEM/REASON FOR EVALUATION:

_____

_____

Date of Onset of Problem/Illness/Injury _____

DEVELOPMENTAL HISTORY:

PLACE OF BIRTH: _____

Birth Complications:

_____	Low Birth Weight	_____	Deformity (specify)
_____	Oxygen Deprivation	_____	Illness (specify)
_____	Premature	_____	Birth Trauma

Developmental Milestones (approximate age in months):

_____	Talking	_____	Standing
_____	Toilet Trained	_____	Walking
_____	No Longer Bedwetting		

Childhood Diseases/Surgeries:

_____	Loss of Consciousness	_____	Seizure
_____	Concussion	_____	Oxygen Deprivation or
_____	Tonsillectomy		Near Drowning
_____	Convulsions	_____	Accidental Poisoning
_____	Encephalitis		(specify substance _____)
_____	Meningitis	_____	Appendectomy
_____	High Fever (over 104° F)	_____	Cerebral Palsy
_____	Pneumonia	_____	Multiple Sclerosis
_____	Allergies	_____	Cut Requiring Stitches
_____	Asthma/Bronchitis	_____	Broken Bones
_____	Cancer	_____	Other _____

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EDUCATIONAL HISTORY:

Special Education Classes or Learning Labs: Yes__ No__ Unknown__
If yes, classes were for _____

_____ Failed Grade
_____ Held Back

IEP _____

Diagnosed Learning Disabilities:
_____ Reading
_____ Spelling
_____ Math

Diagnosed Attentional Problems
_____ ADD
_____ ADHD
_____ Behavioral Problems

Schools Attended:		Dates Attended:	Degree Obtained
High School	_____	_____	_____
College	_____	_____	_____
Vo-Tech During HS	_____	_____	_____
Vo Tech After HS	_____	_____	_____
GED	_____	_____	_____

Academic Performance - Overall Grades Obtained:

_____ High School
_____ Vocational/Technical

_____ College (GPA)
_____ Major

OCCUPATIONAL HISTORY: (Please list most recent jobs first and then past jobs.)

Job	FT/PT	Employer	Approximate Dates	Reason for Leaving

Currently Working: _____ Interested in Returning to Work: _____

Current Income Sources (Circle all that apply): Worker's Comp Social Security Disability Welfare Retirement
Other (specify) _____

DISABILITY:

No: ____ Yes: ____ Type of Disability? _____
Temporary? ____ Permanent? ____ With Whom? _____

MILITARY SERVICE:

Branch: _____
When: _____
Deployments: _____
Exposure to Toxic Substances? ____ Accidents/Illnesses? _____ Shell Shock? _____
Tropical Illnesses? _____ PTSD? _____ (details) _____
_____
Rank: _____ Type of Discharge: _____

LEGAL HISTORY:

Juvenile Problems (truancy, school suspensions, etc.): Yes___ No___

Misdemeanors (DUI, assaults, public intoxication, etc.): Yes___ No___

Felonies (drug possession, fraud, etc.): Yes___ No___

Current Litigation? (I.e., personal injury, liability, etc.): Yes___ No___
Type: Civil Criminal Workers' Comp Unknown
Details: _____

FAMILY HISTORY:

Marital Status/Living Arrangement:

Single:	_____	Separated:	_____	Widowed	_____
Married:	_____	Divorced	_____	Same-Sex Partner	_____

Marital History (list marriages, length, children and reason for termination):

Children (list children and grandchildren: ages, where they live, and occupation if appropriate):

Parents/Stepparents (list names, ages, occupation, and causes of death if deceased):

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FAMILY HISTORY [continued]**:** Siblings and Family Order

	Younger	Older	General Health	Frequency of Contact
Brothers:	_____	_____	_____	_____
Sisters:	_____	_____	_____	_____
Adopted:	_____	_____	_____	_____

MEDICAL HISTORY:

Hospitalizations (Why, when, where, and how long)/Heart attack, stroke or cancer:

_____

_____

_____

_____

Surgeries (type and when):

_____

_____

Trauma requiring medical attention (stitches, fractured bones, falls, automobile accidents, etc.):

_____

_____

_____

_____

HEAD TRAUMA:

Motor Vehicle Accidents (automobile, motorcycle, bicycle, ATV, other, or as a pedestrian):

Military (IED RPG Mortar Grenade Other) Proximity: _____

When: _____ Immediate Tx: _____

Loss of Consciousness (Length): _____ Area of Head Hit: _____

Anterograde/Retrograde Amnesia: _____ Whiplash: _____

Diagnosis: _____ Treatment: _____

Hospitalization: _____

After effects: _____

Vision/Hearing/Memory/Weakness or problems: _____

Dazed/Loss of Consciousness from any Trauma to the Head (e.g., sports, fights, falls, etc.):

When: _____

Loss of Consciousness: _____ Physician: _____

Ear Bleeding: _____ Seizures: _____

Diagnosis: _____ Surgery: _____

Prescription: _____

Hospitalizations: _____

After effects: _____

Vision/Hearing/Memory/Weakness or Other Problems: _____

Penetrating Head Injuries (entered the skull):

When: _____

Loss of Consciousness: _____ Physician: _____

Ear Bleeding: _____ Seizures: _____

Diagnosis: _____ Surgery: _____

Prescription: _____

Hospitalizations: _____

After effects: _____

Vision/Hearing/Memory/Weakness or problems: _____

MEDICAL TESTS (specify dates, physician and findings, if known):

_____ Angiogram (Heart or Head) _____
_____ Brain Scan (CT or MRI) _____
_____ EEG _____
_____ X-Rays (Head or Spine) _____
_____ Spinal Tap _____
_____ Ultrasound _____
_____ Neurological Office Exam _____
_____ PET or PET CT _____
_____ SPECT _____
_____ Other Neuroimaging _____

PSYCHIATRIC HISTORY: (If yes, please explain.)

Hospitalizations (Dates of service and physician/counselor? Why? Was treatment helpful?):

ECT/Chemical Shock Treatment (when, why, number of treatments, memory loss, etc.):

Outpatient Therapy/Counseling (Dates and physician/counselor. Why? Was treatment helpful?):

Previous Psychological Testing (when, where, who, why, results):

Current Stressors (i.e., emotional, physical, financial, occupational, marital, familial, etc.):

Current Medications and Dosages (mg/day - why prescribed, how long, side effects):

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SUBSTANCE USE/ABUSE:

Alcohol:

Current Use (Last 30 days): Yes____ No___ Past Use: Yes _____No____
Problem: Yes____ No____ Dependent or Alcoholic: Yes _____No ___
Length of Use:_____ How Much: _____
Blackouts: Yes No Details: _____
Alcoholic Seizures: Yes No Details: _____
Police Encounters: Yes No Details: _____

Recreational or Illicit Drugs:

Current Use (Last 30 days): Yes ____ No ____ Past Use: Yes _____ No _____
[*If yes above, list drugs, length, how much, periods of heavy use, and date of last use]

Marijuana: _____
Cocaine/Crack: _____
Opiates: _____
Amphetamines: _____
Barbiturates: _____
Hallucinogens: _____
IV Drug Use: _____
Other Drugs: _____

Family History of Substance Use/Abuse:

_____
_____

Prior In/Out Patient Substance or Alcohol Treatment (when, length, & reason):

_____
_____
_____

Tobacco:

Current Use (Last 30 days): Yes___ No ___ Past Use: Yes___ No___
Length of Use:_____ How Much: _____
Type:_____ Problems: _____
Smokeless Tobacco: Chewing____ Snuff ____Dip____

SENSORY/PHYSICAL SYMPTOMS:

Vision:

_____ Glasses/Contacts
_____ Blurred or Double Vision
_____ Loss of Vision/Blind Spots

Tactile: (Specify Location)

_____Numbness/Loss of Sensation
_____Tingling/Burning Sensations
_____Temperature Sensitivity H C

Hearing:

_____ Hearing Aid (R L Both)
_____ Loss of Hearing
_____ Ringing (R L Both)
_____ Tone Deafness

Taste & Smell:

_____ Change in Smell
_____ Bad/Unusual Smells
_____ Change in Taste
_____ Bad/Unusual Tastes

Motor (Specify Location):

_____ Balance
_____ Decreased Coordination
_____ Weakness
_____ Paralysis

_____ Spasms/Tremors
_____ Range of Motion/Flexibility
_____ Chewing/Swallowing
_____ Choking

SENSORY/PHYSICAL SYMPTOMS [continued]**:**

Level of Consciousness:
_____ Seizures or Convulsions
_____ Fainting or Blackout Spells
_____ Lapses of Time
_____ Dizziness While Sitting
_____ Dizziness Upon Standing

Pain (specify where):
_____ Headache (Constant OR Intermittent–Tension, Migraine, Cluster, Sinus, Other)
_____ Neck Pain (Constant OR Intermittent)
_____ Back Pain (Constant OR Intermittent - Upper Mid Lower Throughout)
_____ Chest Pain (Constant OR Intermittent)
_____ Abdominal Pain (Constant OR Intermittent)
_____ Global Pain (Constant OR Intermittent)

COGNITIVE SYMPTOMS:

Attention:
_____ Increased Distractibility
_____ Confusion/Orientation Deficits (Forgetting day, date, or whereabouts)
_____ Concentration Deficits (Difficulty focusing and attending)
_____ Repeatedly read a book or newspaper before it makes sense
_____ Cannot follow television show from start to finish
_____ Path Finding Problems
(Becoming lost when driving in familiar places and/or problems taking a bus)

Learning and Memory:
_____ Memory in General _____
_____ Names
_____ Faces
_____ Numbers
_____ Short-term Recall - Difficulty remembering newly learned experience
_____ Long-term or Remote Recall - Difficulty remembering past experiences/events
_____ Absent-Mindedness
_____ Misplacing things
_____ Forgetting Why You Entered a Room
_____ Old Learning (E.g., balancing a checkbook, recipes, simple math or spelling)
_____ New Learning (E.g., able to learn something new involving 3 or 4 steps)

Speech and Language:
_____ Difficulty Understanding Others
_____ Difficulty Expressing Thoughts
_____ Change in Articulation/Mispronunciation
_____ Stuttering, Slurring or Mumbling When Speaking
_____ Other Speech Impediments
_____ Trouble Finding Correct Word or Desired Word
_____ Saying Wrong or Inappropriate Word
_____ Naming Problems
_____ Hesitations
_____ Substitutions
_____ Difficulty Constructing Sentences

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COGNITIVE SYMPTOMS [continued]**:**

Thought Processes:

_____ Trouble Organizing Thoughts or Actions
_____ Trouble Planning Thoughts or Actions
_____ Slowed Thinking
_____ Decreased Problem Solving Ability
_____ Changes in Ability to Read
_____ Understand Gist
_____ Recall of Information
_____ Changes in Ability to Write Smaller _____ Sloppier _____
_____ Changes in Ability to Spell
_____ Changes in Ability to Perform Mathematical Calculations
_____ Managing finances With Assistance Yes__ No__

EMOTIONAL/PSYCHOLOGICAL SYMPTOMS:

_____ Mood in General _____
_____ Bouts of Inexplicable Crying
_____ Depression/Sadness
_____ Anxiety/Tension/Nervousness
_____ Irritability/Argumentativeness
_____ Temper Outbursts
_____ Impulsiveness
_____ Racing Thoughts
_____ Hyperactivity/Increased Energy/Agitation
_____ Fatigue/Decreased or Low Energy
_____ Decreased Initiative or Follow Through
_____ Change in Motivation
_____ Loss of Pleasure
_____ Social Withdrawal/Isolation
_____ Fears or Worries

SLEEPING PROBLEMS:

_____ Sleep in General _____
_____ Problems Initial Onset Early Middle Late Premature Awakening
_____ Number of Hours per Night on Average
_____ Daytime Napping _____
_____ Refreshing Sleep Yes No
_____ Nightmares [Sleep Terrors Night Sweats]
_____ Polysomnography [When _____]
_____ Sleep Apnea
_____ Restless Leg Syndrome

APPETITE:

_____ Appetite in General _____
_____ Unintentional Weight Change Loss Gain
_____ Intentional Weight Change Loss Gain
_____ Eating Disorder [Type: _____]

PSYCHIATRIC SYMPTOMS:

_____ Changes in Libido _____
_____ Mood Swings _____

PSYCHIATRIC SYMPTOMS [continued]:
_____ Acute Anxiety/Panic Attacks _____
_____ Hallucinations Auditory Visual _____
_____ Delusional Thinking _____

Suicidality:
_____ Previous Suicidal/Homicidal Thoughts/Ideation
_____ Previous Intent or Plans
_____ Previous Suicide Attempts
_____ Current Suicidal/Homicidal Thoughts/Ideation
_____ Current Intent or Plans

Abuse:
_____ Military Sexual Trauma
_____ Uninvited and/or unwanted sexual attention
_____ Force or threat of force to have sexual contact against your will
_____ Previous abuse
_____ Rape, molestation, or other form of sexual abuse
_____ Physical abuse
_____ Verbal abuse
_____ Emotional abuse
_____ Other maltreatment or neglect

FAMILY MEDICAL HISTORY - PSYCHIATRIC PROBLEMS:
Please indicate if these apply to you or specify a family member.

Self	Family Member	
____	_____	Alzheimer's Disease or other Dementia
____	_____	Parkinson's Disease
____	_____	Depressive Disorder
____	_____	Anxiety Disorder
____	_____	Schizophrenia or Psychotic Disturbance
____	_____	Bipolar Disorder (i.e., Manic Depressive Illness)
____	_____	Nervous Breakdowns
____	_____	Personality Disorder
____	_____	ECT/Inpatient Hospitalization
____	_____	Substance Abuse (i.e., Drug Use)
____	_____	Alcoholism or Excessive Drinking
____	_____	Periods of Prolonged Use of Prescription Medications
____	_____	Headaches (specify type) _____
____	_____	Neck Pain
____	_____	Back Pain
____	_____	Arthritis
____	_____	Sexual Abuse
____	_____	Rape
____	_____	Physical Abuse
____	_____	Verbal Abuse
____	_____	Emotional Abuse
____	_____	Other Maltreatment or Neglect
____	_____	Other Mental Health Problems, Conditions or Diseases (Specify) _____

_____

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FAMILY MEDICAL HISTORY - MEDICAL PROBLEMS [continued]:
Please indicate if these apply to you or specify a family member.

Self Family Member

____ _____ Birth Problems/Trauma _____
____ _____ Cerebral Palsy
____ _____ Mental Retardation
____ _____ Cystic Fibrosis
____ _____ Polio Myelitis/Infantile Paralysis
____ _____ Rheumatic Fever
____ _____ Scarlet Fever
____ _____ Learning Disability
____ _____ Diabetes
____ _____ High Blood Pressure (i.e., Hypertension)
____ _____ High Cholesterol (i.e., Hypercholesterolemia)
____ _____ Heart Attacks (Angina, Myocardial Infarction)
____ _____ Strokes (CVA, TIA)
____ _____ Encephalitis (Brain Infection)
____ _____ Malaria
____ _____ Pneumonia
____ _____ Venereal Diseases
____ _____ HIV/AIDS Status (When tested & Results) _____
____ _____ Tuberculosis (TB)
____ _____ Other Infections (Specify) _____
____ _____ Cancer (Specify Location) _____
____ _____ Heat Stroke
____ _____ High Fever (Over 104°)
____ _____ Asthma/Respiratory Problems
____ _____ Lung Diseases (Specify) _____
____ _____ Blood Diseases (Specify) _____
____ _____ Kidney/Liver Diseases (Specify) _____
____ _____ Ulcers/Other Gastrointestinal Problems
____ _____ Tumor (Benign, Specify Location) _____
____ _____ Seizures or Convulsions
____ _____ Epilepsy
____ _____ Tremors/Chorea
____ _____ Chorea/St. Vitus Dance
____ _____ Paralysis or Other Motor Problems (Specify) _____
____ _____ Exposure to/Overcome by Toxic Substances - Solvents Paints
____ _____ Gasses Chemicals Fumes
____ _____ Electric Shock - Lightning
____ _____ Electric Shock - High voltage or high tension wires
____ _____ Period without Air (e.g., Anoxia, Hypoxia)
____ _____ Loss of Consciousness (Specify Cause) _____
____ _____ Fainting (i.e., Syncope)
____ _____ Head Injury
____ _____ Concussion
____ _____ Coma
____ _____ Surgeries Requiring General Anesthesia
____ _____ Other Medical Problems, Conditions or Diseases (Please Specify)
_____

OTHER RELEVANT INFORMATION:

QUESTIONS FOR THE DOCTOR:

NOTES: