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Please complete all questions within this questionnaire. Please answer them as accurately and completely as possible. It is preferred that you complete the questions yourself, but you may have a spouse, or significant other, help you if needed. Please remember to bring the completed questionnaire with you to your appointment. Thank you for your kind cooperation.

Patient name: _____ DOB: _____

Home Address: _____

Home Phone: _____ Work: _____ Cell: _____

Email _____ Preferred call-back number: Home ☐ / Work ☐ / Cell ☐

Name of person filling out form _____ Relationship to patient _____

Who referred patient for evaluation? _____ Phone : _____

What is the primary reason for the referral? _____

PRESENTING PROBLEM(S)

Are you having problems with:		Are you having problems with:		Are you having problems with:	
vision	Yes ☐ No ☐	alertness	Yes ☐ No ☐	irritability	Yes ☐ No ☐
		anger	Yes ☐ No ☐	memory	Yes ☐ No ☐
hearing	Yes ☐ No ☐	anxiety	Yes ☐ No ☐	pain	Yes ☐ No ☐
		appetite	Yes ☐ No ☐	reading	Yes ☐ No ☐
smell	Yes ☐ No ☐	balancing checkbook	Yes ☐ No ☐	sadness	Yes ☐ No ☐
		comprehension	Yes ☐ No ☐	sense of direction	Yes ☐ No ☐
taste	Yes ☐ No ☐	concentration	Yes ☐ No ☐	sleep	Yes ☐ No ☐
		confusion	Yes ☐ No ☐	speech	Yes ☐ No ☐
touch	Yes ☐ No ☐	coordination	Yes ☐ No ☐	understanding others	Yes ☐ No ☐
		depression	Yes ☐ No ☐	walking	Yes ☐ No ☐
balance	Yes ☐ No ☐	driving	Yes ☐ No ☐	weakness	Yes ☐ No ☐
		fatigue	Yes ☐ No ☐	word finding	Yes ☐ No ☐
voice	Yes ☐ No ☐	headaches	Yes ☐ No ☐	writing	Yes ☐ No ☐

Briefly describe the problems (symptoms) that caused you to seek evaluation.

When did these problems begin (approximate date): _____. Have your symptoms worsened, gotten better or stayed the same since they first began? Explain if necessary.

1. To the best of your knowledge, what is the cause of these problems?

2. What questions would you like answered by this evaluation?

GENERAL INFORMATION

Date of Birth: _____ Age: _____ Sex: _____

Height: _____ Weight: _____

Primary language: _____ Race: _____

I am: Left-handed Right-handed

I am: Single Married Long-Term Relationship Separated Divorced Widowed

Number of years married or in current relationship: _____ Number of times married:_____

I live: alone with spouse/family with friend with room-mate

I live in: house apartment condo/town-home assisted-living or residential facility

CHILDHOOD MEDICAL HISTORY

1. You were born: _____ On time _____ Prematurely _____ Late

2. Your weight at birth: _____ pounds _____ ounces

3. Were there any problems associated with your birth (e.g. oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g. need for oxygen, special equipment used, convulsions, illness, etc.)? _____ Yes _____ No

If yes, please describe

4. Check all that apply to your mother while she was pregnant with you:

_____ Accident
_____ Alcohol use
_____ Cigarette smoking
_____ Drug use (marijuana, speed, cocaine, LSD, etc.)
_____ Illness (toxemia, diabetes, high blood pressure, infection, Rh incompatibility, etc.)
_____ Poor nutrition
_____ Psychological problems
_____ Other problems: _____

5. Rate your developmental progress as it has been reported to you by checking one description for each area:

	Early	Average	Late
Walking	_____	_____	_____
First words	_____	_____	_____
Toilet Training	_____	_____	_____
Overall Development	_____	_____	_____

6. As a child, did you have any of these conditions? (Check all that apply.)

_____ Attention Problems _____ Head Injury _____ Muscle Tightness or Weakness
_____ Clumsiness _____ Hearing Problems _____ Speech Problems
_____ Developmental Delay _____ Hyperactivity _____ Vision Problems
_____ Frequent ear infections _____ Learning Disability _____ Other:_____

7. Check all the conditions that were diagnosed when you were a child. Add any helpful details (age at diagnosis, treatment provided, etc.)

_____ Allergies	_____ Epilepsy or seizures	_____ Pneumonia
_____ Asthma	_____ Fevers (104º or higher)	_____ Poisoning (lead or other)
_____ Brain infection or disease	_____ Heart problems	_____ Polio
_____ Cancer	_____ Immune system disease	_____ Rheumatic Fever
_____ Cerebral Palsy	_____ Kidney problems	_____ Scarlet Fever
_____ Chicken pox	_____ Lung (respiratory) disease	_____ Tuberculosis
_____ Colds (excessive)	_____ Measles	_____ Venereal disease
_____ Diabetes	_____ Meningitis	_____ Whooping Cough
_____ Encephalitis	_____ Oxygen deprivation	_____ Mumps

_____ Other diseases or illnesses: _____

_____

8. As a child, were you ever hospitalized? Yes _____ No _____

If yes, please describe what happened: _____

9. How would you describe your nutrition as a child and adolescent?

Excellent _____ Average _____ Poor _____

10. List all medications that were regularly given to you as a child:

Medication	Reason for the medication
a) _____	_____
b) _____	_____
c) _____	_____
d) _____	_____

ADULT MEDICAL HISTORY

1. Please list all of your ***current*** medications (with dosage), the reason you take them, how long you have been taking them and any side effects you have noticed (e.g., nausea, sleepiness, etc.). Include both prescription and over-the-counter medications.

Medication	Reason	How Long?	Side Effects (if any)

2. Have you had any of the following tests performed? Please indicate date(s) and summarize findings.

	Date	Where completed?
CT/MRI Scan of brain	_____	_____
EEG (brain waves)	_____	_____
Spinal Tap	_____	_____
Other	_____	_____

List below the names of all of the doctors who currently treat you.

Name	Address	Specialty (PCP, Neurologist, Internist, Psychiatrist, etc.)

3. List below all prior hospitalizations, along with dates, reason for hospitalization, and treatments you received:

Approximate Date	Hospital	Reason	Treatment

4. Have you had psychiatric, psychological or mental health evaluation and/or treatment?

Date	Name of Doctor	Location	Nature of Problem

5. Do you smoke? If so, how much? _____

6. Do you drink alcohol currently? If so, how much per week? _____
   Did you ever have a period of time that you drank alcohol to excess or had problems using non-prescription drugs? If so, when? _____
   Have you ever received treatment for alcohol or drug abuse? If so, when? _____
   _____

7. Have you ever been to our clinic before or had a neuropsychological evaluation performed before? If so, when? _____

8. Please indicate whether you or a member of your family has ever been diagnosed with any of the following conditions:

	Self	Family Member
Cancer/Tumors		
Diabetes		
High Blood Pressure		
Heart Disease		
Heart Attack/Angina		
Lung Disease		
Stroke		
Head Injury		
Seizures/Epilepsy		
Learning Disability		
Parkinson's Disease		
Huntington's Disease		

"Senility"/Alzheimer's Disease		
Psychiatric Illness		
Depression		
Anxiety		

9. Please rate your overall health at the present time.

   Circle one: Poor Fair Good Excellent

EDUCATIONAL AND OCCUPATIONAL HISTORY/CURRENT INTERESTS

In school: Did you ever repeat a grade? Yes **O** No **O**
If yes, which grade(s) _____

Were you ever placed in special classes? Yes **O** No **O**
If yes, what kind of classes and in which grades: _____
Did you ever receive any other type of special services in school? Yes **O** No **O**
If yes, what kind of services and in which grades: _____

	Name of school	Year graduated	Degree	Major/Focus
High school				
2 yr College				
University				
Post graduate study				
Post graduate study				

At work: are you employed outside the home? Yes No
If yes, what is your occupation? _____ How many hours per week do you work? ___
If no, are you unable to work because of an injury or illness? Yes No
Last date worked: _____ If you are not working now, what was your former occupation? _____

In the table below, please outline your work history, starting with your present job and working backwards. If you are retired or unemployed, indicate this in the first row and complete the remainder of the table with your past jobs.

Occupation Approximate Dates (from/to) Duties

_____
_____
_____
_____
_____

1. If you are still working, has your current illness or problem affected your ability to do your job? If retired or unemployed, has it affected your ability to perform daily activities and chores? If so, please describe.

2. List all activities (e.g. organizations, sports, etc.) in which you currently participate. Also list any hobbies or interests you currently pursue.

COMPENSATION/LITIGATION

1. Are you currently receiving disability compensation as a result of current or past illness?
   Yes _____ No _____
   If yes, for what illness/disability are you benefits related to?_____

2. Are you currently involved in a lawsuit or other legal action related to the illness for which you are being evaluated?
   Yes _____ No _____
   If yes, please specify: _____