

**AARON N. JUNI, PH.D.**

CLINICAL NEUROPSYCHOLOGIST, DIRECTOR

**NEUROPSYCHOLOGY CENTER OF MARYLAND, LLC**

11K Gwynns Mill Court  
Owings Mills, Maryland 21117

TELEPHONE: (443) 379-0033

WEB: WWW.MDNEUROPSYCH.COM

FAX: (443) 213-1502

EMAIL: DRAARONJUNI@MDNEUROPSYCH.COM

**NEUROPSYCHOLOGY QUESTIONNAIRE**

**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 <input type="checkbox"/> No <input type="checkbox"/> | alertness                      | Yes <input type="checkbox"/> No <input type="checkbox"/> | impulsivity                   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|                               |  | anger management               | Yes <input type="checkbox"/> No <input type="checkbox"/> | irritability                  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| hearing                       | Yes <input type="checkbox"/> No <input type="checkbox"/> | anxiety                        | Yes <input type="checkbox"/> No <input type="checkbox"/> | memory                        | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|                               |  | attention and/or concentration | Yes <input type="checkbox"/> No <input type="checkbox"/> | pain                          | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Smell/taste                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | balancing checkbook            | Yes <input type="checkbox"/> No <input type="checkbox"/> | personality changes           | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|                               |  | Comprehending spoken language  | Yes <input type="checkbox"/> No <input type="checkbox"/> | reading                       | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| touch                         | Yes <input type="checkbox"/> No <input type="checkbox"/> | confusion                      | Yes <input type="checkbox"/> No <input type="checkbox"/> | sadness or loss of motivation | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|                               |  | coordination                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | sense of direction            | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| balance                       | Yes <input type="checkbox"/> No <input type="checkbox"/> | depression                     | Yes <input type="checkbox"/> No <input type="checkbox"/> | sleep                         | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|                               |  | driving                        | Yes <input type="checkbox"/> No <input type="checkbox"/> | word-finding                  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| speech                        | Yes <input type="checkbox"/> No <input type="checkbox"/> | fatigue                        | Yes <input type="checkbox"/> No <input type="checkbox"/> | writing                       | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Describe the issues and concerns that lead you to seek evaluation.

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

When did problems begin (date) :\_\_\_\_\_ How have symptoms changed since then?

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

To the best of your knowledge or speculation, what may be causing or exacerbating these problems?

\_\_\_\_\_
\_\_\_\_\_

What questions would you like answered by this evaluation?

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

GENERAL INFORMATION

Age:\_\_\_\_\_ Sex:\_\_\_\_\_ Height:\_\_\_\_\_ Weight:\_\_\_\_\_
Primary language:\_\_\_\_\_ Handedness: [ ]Left-handed [ ]Right-handed [ ]Ambidextrous
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 a(n): [ ] house [ ] apartment [ ] condo/townhome [ ] residential facility\_\_\_\_\_

CHILDHOOD MEDICAL HISTORY

1. You were born: [ ]On time [ ]Premature:\_\_\_\_\_ [ ]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:

Substance Use                       Medical Illness                       Mental Health Issues                       Other

Please describe: \_\_\_\_\_

5. Please rate your developmental progress (to the best of your knowledge) in each of the following areas:

|                     |                                |                                  |                               |
|---------------------|--------------------------------|----------------------------------|-------------------------------|
| Walking             | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |
| First Words         | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |
| Toileting           | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |
| Overall Development | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |

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

|  |  |   |
|--|--|---|
| <input type="checkbox"/> Attention Problems      | <input type="checkbox"/> Head Injury         | <input type="checkbox"/> Muscle Tightness or Weakness |
| <input type="checkbox"/> Clumsiness              | <input type="checkbox"/> Hearing Problems    | <input type="checkbox"/> Speech Problems              |
| <input type="checkbox"/> Developmental Delay     | <input type="checkbox"/> Hyperactivity       | <input type="checkbox"/> Vision Problems              |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Other: _____                 |

7. Indicate all diagnosed/treated childhood conditions.

|   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergies                  | <input type="checkbox"/> Epilepsy or seizures       | <input type="checkbox"/> Oxygen Deprivation        |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> High Fevers (104° +)       | <input type="checkbox"/> Poisoning (lead or other) |
| <input type="checkbox"/> Brain infection or disease | <input type="checkbox"/> Heart problems             | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Immune system disease      | <input type="checkbox"/> Scarlet Fever             |
| <input type="checkbox"/> Cerebral Palsy             | <input type="checkbox"/> Kidney problems            | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Lung (respiratory) disease | <input type="checkbox"/> Venereal disease          |
| <input type="checkbox"/> Encephalitis               | <input type="checkbox"/> Measles/Mumps              | <input type="checkbox"/> Whooping Cough            |

Other: \_\_\_\_\_

\_\_\_\_\_

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

If yes, please describe: \_\_\_\_\_

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 | How Long? | Side Effects (if any) |
|------------|--------|-----------|-----------------------|
|            |        |           |                       |
|            |        |           |                       |
|            |        |           |                       |
|            |        |           |                       |

**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. For each of the following diagnostic tests, please indicate date(s) and summarize the findings.

|                      | Date(s) | Findings |
|----------------------|---------|----------|
| CT/MRI Scan of brain | _____   | _____    |
| EEG (brain waves)    | _____   | _____    |
| Spinal Tap           | _____   | _____    |
| Other                | _____   | _____    |

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

| Name | Location | Specialty (PCP, Neurologist...) |
|------|----------|---------------------------------|
|      |          |                                 |
|      |          |                                 |
|      |          |                                 |
|      |          |                                 |

4. Please detail prior hospitalizations, including reason for hospitalization and treatments received:

| Approximate Date | Hospital | Reason | Treatment |
|------------------|----------|--------|-----------|
|                  |          |        |           |
|                  |          |        |           |
|                  |          |        |           |
|                  |          |        |           |

5. Please detail previous psychiatric, psychological and mental health treatment?

| Date(s) | Name of Doctor | Location | Nature of Problem |
|---------|----------------|----------|-------------------|
|         |                |          |                   |
|         |                |          |                   |
|         |                |          |                   |
|         |                |          |                   |

6. Do you smoke? If yes, how much? \_\_\_\_\_

7. Do you drink alcohol currently? If so, how much per week? \_\_\_\_\_

8. Please describe in detail any current or past substance abuse and/or treatment: \_\_\_\_\_

\_\_\_\_\_

9. Please list previous psychological and neuropsychological evaluations and approximate date(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

10. Please provide details reading personal and family medical history below:

|                            | Self | Family Member |
|----------------------------|------|---------------|
| Cancer                     |      |               |
| Diabetes                   |      |               |
| High Blood Pressure        |      |               |
| Cardiac Disease / symptoms |      |               |
| Stroke                     |      |               |
| Head Injury                |      |               |
| Seizures/Epilepsy          |      |               |
| Learning Disability        |      |               |
| Dementia or "senility"     |      |               |
| Parkinson's Disease        |      |               |
| Anxiety/Depression         |      |               |
| Mental Health/Psychiatric  |      |               |
| Other                      |      |               |

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

Choose one:  Poor  Fair  Good  Excellent

**EDUCATIONAL AND OCCUPATIONAL HISTORY/CURRENT INTERESTS**

|                     | Year graduated | Degree | Major/Focus |
|---------------------|----------------|--------|-------------|
| High school         |                |        |             |
| 2 yr College        |                |        |             |
| University          |                |        |             |
| Post graduate study |                |        |             |
| Post graduate study |                |        |             |

Did you ever repeat a grade? Yes  No

If yes, please describe: \_\_\_\_\_

Have you ever been placed in special education classes? Yes  No

If yes, please describe: \_\_\_\_\_

Please describe all forms of academic or vocational accommodations/supports you have received.

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What is your current occupation? \_\_\_\_\_ Average work hours per week? \_\_\_\_\_

**If you are not working**, are you unable to work because of an injury or illness? Yes  No

What was your former occupation? \_\_\_\_\_ Last date worked: \_\_\_\_\_

Please outline your work history in the table below, starting with your present job and working backwards.

If retired or unemployed, indicate this in the first row and complete rest of table with past work history.

| Occupation | Approximate Dates (from/to) | Duties |
|------------|-----------------------------|--------|
|------------|-----------------------------|--------|

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Please describe how current symptoms impact employment, activities, relationships, and emotional state.

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List all activities (e.g. organizations, sports, etc.) and hobbies in which you currently participate.

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**COMPENSATION/LITIGATION**

Are you currently receiving compensation as a result of current or past illness or injury? Yes  No

**If yes**, please describe: \_\_\_\_\_

Are you currently involved in any legal action related to illness or injury? Yes  No

**If yes**, please describe: \_\_\_\_\_