BACKGROUND QUESTIONNAIRE

Confidential Information

In preparation for your Neuropsychological Evaluation, I ask that you complete the following questions. Please answer them completely and in as much detail as possible. Feel free to write on the last page of the questionnaire or use additional sheets, as necessary. I prefer that you complete the questions yourself, but if necessary, you may have a relative or friend assist you. Please bring this completed questionnaire with you to your evaluation.

Patient Name:_____ Date Completed: ___/___/_____

Address: _____ Phone: (home)_____

_____ (work) _____

(cell) _____

Date of Birth:___/___/_____ Age: ____ Marital Status:_____

Handedness: Right Left Both Education:_____

(Highest Grade Completed)

If another person assisted in completing this form, provide information about him/her:

Name: _____ Relationship to Patient:_____

Address: _____ Phone: (home)_____

_____ (work) _____

(cell) _____

If necessary, may this person be contacted for additional collateral information: _____

Referral Information: Who referred you for this evaluation? _____

To the best of your knowledge, why were you referred for this assessment?

_____

_____

_____

_____

What would you like to learn about yourself or accomplish from this evaluation?

_____

_____

_____

_____

Medical Information: Briefly describe what problems or symptoms led you to seek help from your current treatment providers.

_____

_____

_____

_____

List five problems or symptoms that currently cause you the most difficulty (with #1 being the worst problem or symptom).

1. _____
2. _____
3. _____
4. _____
5. _____

Approximately when did these problems/symptoms begin? _____

Have your symptoms (circle one): Gotten Worse? Gotten Better? Stayed the Same?

To the best of your knowledge, what is/was the cause(s) of these problems?

_____

Current Physicians/Therapists: Please list all your current treatment providers.

Name	City, State	Phone	Specialty	How long?

Current Medications: Please list all medications you are taking (including over-the-counter drugs).

Medication (name and dose)	Reason Taking	How long?

Prior Psychological/Neuropsychological Evaluations or Neurological Tests: Please list any previous evaluations/tests.

Date	Doctor	City, State	Reason Evaluated

Background Questionnaire (continued)

Medical Hospitalizations: Please list any medical hospitalizations.

Date	Hospital Name/Location	Reason Hospitalized

Medical History: Please note if you have any of these conditions/illnesses listed below and the date you were diagnosed. Provide details about the conditions/illness on a separate sheet. Also, note if any of your relatives have these conditions as well.

	Self (Date Diagnosed)	Relative
Diabetes		
Heart Disease		
High Cholesterol		
High Blood Pressure		
Cancer (type_____)		
Chemotherapy/Radiation		
Hormonal Problems		
Lung/Breathing Problems		
Near Drowning		
Anemia		
HIV/AIDS		
Liver Problems		
Kidney Problems		
Thyroid/Endocrine Problems		
Severe Allergic Reactions		
High Fever (>104 degrees)		
Electric Shock		
Birth/Developmental Problems		
Epilepsy		
Stroke		
TIA (transient ischemic attacks)		
AVM (arteriovenous malformation)		
TBI/Concussion		
Loss of Consciousness		
Lyme Disease		
Meningitis		
Encephalitis		
Toxic Exposure		
Brain Cyst/Growth		
Huntington's Disease		

	Self (Date Diagnosed)	Relative
Parkinson's Disease	_____	_____
Multiple Sclerosis	_____	_____
Other:_____	_____	_____
_____	_____	_____
_____	_____	_____

Please place a check in the space before the symptom(s) that apply to you that are listed below. Provide additional details on a separate sheet, as appropriate.

Physical Symptoms:

_____ Difficulty walking

_____ Balance Problems

_____ Reduced Strength - Where?

_____ Tremor/Shakiness

_____ Involuntary or Repetitive Movements

_____ Reduced Fine Motor Skills (using pencil, scissors, keys)

_____ Reduced Sense of Touch – Where?

_____ Change in Handwriting

_____ Hearing Problems

_____ Ringing in Ears

_____ Vision Problems

_____ Double Vision

_____ Reduced Sense of Smell

_____ Reduced Sense of Taste

_____ Pain – Where?

_____ Headaches

_____ Dizziness/Lightheadedness

_____ Nausea/Vomiting

_____ Continence Problems

_____ Sexual Dysfunction

_____ Lack of Energy

_____ Problems with Sleep

_____ Change in Appetite

_____ Significant Loss/Gain in Weight

Cognitive Symptoms:

Attention/Concentration Difficulties

Do you...

_____ have difficulty paying attention
_____ have problems focusing/concentrating on tasks
_____ often lose your train of thought when doing something or when talking
_____ become easily confused or distracted

Other: _____

Background Questionnaire (continued)

Processing Speed Difficulties

Do you find...

_____ that it takes you longer to process information
_____ that your thoughts are slower
Other: _____

Speech/Language Problems

Do you...

_____ misname objects
_____ have trouble finding words
_____ notice a change in the quality and control of your speech?
Slurred? Louder/Softer? Rambling? Jump from one topic to next?
_____ have trouble understanding what others are saying
_____ have trouble expressing yourself with words
_____ have problems spelling
Other: _____

Reasoning and Non-Verbal Difficulties

Do you...

_____ have trouble with multiple-step activities
_____ have difficulty recognizing familiar objects or people
_____ have trouble making change with small sums of money
_____ have trouble making decisions
Other: _____

Memory Problems

Do you have difficulty remembering...

_____ where objects are placed (e.g. keys)
_____ that appliances are on
_____ appointments
_____ to take medications
_____ to pay bills
_____ activities you were just doing
_____ plans you made for the day
_____ what you just read
_____ where you are going when driving or walking
_____ events that only happened minutes or hours ago
_____ events that happened long ago (months, years)
_____ how to perform an activity you used to know how to do quite well
Other: _____

Do hints or cues help you to remember? (circle one): helps does not help

Emotional Symptoms and Behavioral Difficulties:

_____ Depression/Sadness _____ Anxiety/Nervousness

_____ Panic Attacks _____ Phobias

_____ Anger/Irritability _____ Aggressive/Violent

_____ Impulsive/Disinhibited _____ Unusual Behaviors

_____ Bizarre/Strange Feelings _____ Suspicious/Paranoia

_____ Hallucinations/Illusions (voices, visions, skin sensations)

_____ Thoughts of Harming Self or Another

Other: _____

Daily Functioning:

Please note (using the 1-to-10 scale below) how much assistance you now require to perform the following daily tasks by placing the appropriate number in the space to the left of each statement. Check the N/A space to the right of the statement if the item is not applicable (e.g., you never did these things yourself).

Independent **Moderate Assistance** **Maximum Assistance**

1----------2---------3---------4---------5---------6---------7---------8---------9---------10

Current Rating **N/A**

_____ Basic ADL's (dressing, bathing, feeding, walking, transferring, etc.) _____

_____ Complex ADL's (meal planning, grocery shopping, trip planning, etc.) _____

_____ Money Management (paying bills, balancing checkbook, etc.) _____

_____ Medication Management _____

_____ Driving _____

Substance Use:

Alcohol

Do you drink alcohol? Yes No If no, did you drink alcohol in the past? Yes No

What is your average current alcohol consumption (i.e., list average # drinks per day, week, etc.)?

_____ Preferred drink (including size)_____

Was there a time when your alcohol consumption was heavier than present? Yes No

Background Questionnaire (continued)

Have you had problems due to your alcohol consumption (e.g., injuries, legal problems, family conflicts, work problems)? Yes No

Have you ever experienced withdrawal symptoms after stopping use of alcohol (e g., sweats, shakes, hallucinations, etc.)? Yes No

Have you ever had a blackout (i.e., unable to recall a period of time when you had been using alcohol)? Yes No

Is there a history of alcohol abuse in your family? Yes No

Have you ever been involved in alcohol treatment? Yes No

Illicit Drugs

Do you use illicit/street drugs? Yes No If no, did you use drugs in the past? Yes No

Check all that you have used (and list how much, how often):

_____ Marijuana/Hashish_____
_____ Amphetamines (e.g., speed)_____
_____ Cocaine/Crack_____
_____ Hallucinogens (e.g., LSD, mushrooms, etc.)_____
_____ Inhalants (e.g., nitrous oxide, glue, etc.)_____
_____ Opiates (e.g., heroin, morphine, etc.) _____
_____ Designer Drugs (e.g., ecstasy, GHB, etc.)_____
_____ Prescription Drugs (e.g., Oxycontin, Xanax, etc.)_____
_____ Others (please list)_____

Have you ever used IV drugs? Yes No
Have you ever over-dosed on drugs? Yes No
Any problems related to your drug use (e.g., legal problems, family conflicts)? Yes No
Is there a history of drug abuse in your family? Yes No
Have you ever been involved in drug treatment? Yes No

Tobacco

Do you smoke (cigarettes, cigars, pipes) or use smokeless tobacco? Yes No
For how long? _____ Average daily use_____
If quit, when? _____

Caffeine

Do you drink caffeinated beverages? Yes No
Average daily use_____

Over-The-Counter Drugs

Do you regularly use over-the-counter medicines (sleeping pills, pain drugs)? Yes No
Have you ever used performance-enhancing drugs/substances (e.g. steroids)? Yes No

Mental Health History: Please list any psychiatric/psychological care you have received.

Dates Provider Name/Location Reason Treated

Have you ever been **psychiatrically hospitalized**? Yes No (if yes, complete the following):

Dates Hospital Name/Location Reason Hospitalized

Have you ever been prescribed **psychiatric medications**? Yes No

(if yes, complete the following):

Dates Drug Name Reason Taken

Have you ever undergone Electroconvulsive Therapy (ECT)? Yes No

Have any of your family members received treatment for psychiatric problems? Yes No

Personal Information:

Where were you born? _____

Circle one: Single Birth Twin Triplet Other: _____

Were there any problems/complications with your birth? Yes No (If yes, describe on reverse)

Difficulties with your early development (e.g., walking, talking, toileting, etc)? Yes No

Family of Origin:

	Age (or age at death)	Education	Primary Job	Health
Father				
Mother				
Siblings				

Current Marital Status: _____ Lists date(s) of marriage/divorce: _____

Children: Name Gender (M/F) Age Health

Background Questionnaire (continued)

Religious Denomination_____

List your recreational interests or hobbies you enjoy. If appropriate, describe how these have been affected by your medical situation.

Education:
High grade/degree completed in school _____ Year graduated_____

List the colleges, technical, and/or vocational schools you have attended (list most recent first):

Name	Years Attended	Primary/Major Area of Study

(continue on other side, if necessary)

What were your academic strengths in school?

What were your academic weaknesses in school?

Were you ever held back any grades? Yes No If so, what grades? _____
Were you ever diagnosed with a learning disability? Yes No
If you had difficulty in school, describe any special assistance or help you received:

Describe any behavior problems you had in school:

List any extracurricular school activities in which you participated (e.g., sports, clubs, etc.):

What are your plans for education in the future?

Employment:
Are you currently employed? Yes No If not, when did you last work? _____

List your work history beginning with your current job and going backwards:

Occupation	From To	Reason for Leaving

Occupation	From To	Reason for Leaving

(continue on a separate sheet, if necessary)

Which of these jobs was your most significant?

If relevant, describe how your current illness has affected your ability to work:

What are your future employment plans?

Compensation/Litigation: Circle one for each.

Do you currently receive Social Security Benefits?	Yes	No
Do you currently receive Worker's Compensation Benefits?	Yes	No
Are you currently receiving any disability compensation as a result of your illness?	Yes	No
Are you currently receiving disability compensation for past illnesses?	Yes	No
Are you currently involved in a lawsuit or other legal action?	Yes	No

Current Attorney: Please list the names of any legal counsel that are currently assisting you.

Name	City, State	Phone	Reason