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BACKGROUND QUESTIONNAIRE
Confidential Information

In preparation for your neuropsychological evaluation, please complete the following questionnaire by answering all items in as much detail as possible. If you are able, complete this form independently. Otherwise, you may have a relative or friend assist you. Please bring this completed questionnaire and relevant medical, assessment, and/or academic records with you to your evaluation.

Patient Information

Name: _____ Date of Birth: _____ Gender: _____ Age: _____
Mailing Address: _____ Highest Grade/Degree completed: _____
_____
Home Phone: _____ Handedness (circle one):
Work Phone: _____
Cell Phone: _____ **Left Right Both**

Referral Information: Who referred you for this evaluation? Also note current treatment providers and indicate to whom you would like us to release a copy of this report.

Specialty	Name	Address	Phone & Fax	Length of Treatment	Request Release of Information?
Primary Care					Yes No
Neurology					Yes No
Physiatry/ Rehabiliation					Yes No
Psychiatry					Yes No
Psychotherapy/ Counseling					Yes No
					Yes No

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

_____

_____

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

_____

_____

Have you ever had a Neuropsychological or Psychological evaluation? **Yes** **No**

If yes, when and with whom? (If results are available please bring us a copy): _____

_____

Social Information: Where were you born? _____

If outside of the United States, at what age did you move to the U.S.? _____

What is your primary (everyday) language(s)? _____

Any secondary languages? _____

Were there problems/complications with your birth? **Yes** **No** If yes, please describe on reverse.

Were there difficulties with your early development (e.g., walking, talking, toileting, etc)? **Yes** **No**

Family Members	Age or age at death	Education	Primary Job	Mental & Physical Health
Father				
Mother				
Siblings				

Current Marital Status: **Single Married Divorced Widowed** # of Marriages**: ____** # of Divorces**: ___**

Children	Date of Birth	Age	Gender	Mental & Physical Health

Religious Denomination (if applicable): _____

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

Education:

Highest grade/degree completed in school: _____ Year graduated: _____

If college, where and what was your major? _____

What were your strengths in school? **English Math History Language Social Studies Science Arts Other**:_____

What were your weaknesses in school? **English Math History Language Social Studies Science Arts Other:**_____

Were you ever held back/repeated any grades? **Yes** **No** If so, which grade(s)? _____

Were you ever diagnosed with a learning disability or related condition? **Yes** **No**

Did you receive any special assistance or special education services? **Yes** **No**

Describe any behavior problems you had in school:

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

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

Dates of Employment (From – To)	Occupation/Title	Reason for Leaving

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

What are your future employment goals?:

Compensation/Litigation/Legal:

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 illness or injury?	**Yes**	**No**
Have you applied or do you plan to apply for disability or other benefits?	**Yes**	**No**
Are you currently involved in a lawsuit or other legal action?	**Yes**	**No**

Current Attorney: List the name and contact information for any legal counsel currently assisting you:

Name **Phone & Fax** **Reason**

Do you have a will? **Yes** **No**

Do you have a Living Will? **Yes** **No**

Have you given someone Power of Attorney? **Yes** **No**
If Yes, who? _____

Do you have a conservator? **Yes** **No** **If Yes, who:** _____

Current Symptoms:
List **primary** problems or symptoms that currently cause you the most difficulty (with #1 being the worst).
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 caused these problems?

Cognitive Symptoms: Please check the space before any of the symptoms below that apply to you

Attention

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?
___ have trouble multi-tasking?
Other:

Processing Speed

Does it seem…

___ it takes you longer to process information?
___ your thoughts are slower?

Language/Speech

Do you…

___ have trouble finding words?
___ notice a change in the quality and control of your speech? (circle)
slurred louder softer rambling jumping topics
___ have trouble understanding what others are saying?
___ have trouble expressing yourself with words?
___ have problems spelling?
Other:

Executive Functioning

Do you…

___ find it is harder to be organized?
___ have trouble thinking through or following through with tasks?
___ have trouble carrying out multi-step tasks?
___ have trouble making decisions?

Visual-Spatial

Do you…

___ become lost?
___ have trouble with long division, geometry, etc?
___ bump into walls, stumble, or seem clumsy?
___ have using routine objects/appliances (e.g., microwave, remote control)?

Memory

Do you forget…

___where objects are placed (e.g. keys, wallet)
___that appliances are on
___appointments or plans you made for the day
___to take medications
___to pay bills
___activities you were just doing
___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)
Other:

Do you find that cues/hints help you remember? **Yes** **No**

Physical Symptoms: Please place a check in the space before the symptom(s) you are currently experiencing. If needed, provide additional details on a separate sheet.

___Difficulty walking
___Balance Problems
___Numbness/tingling
___Hearing Problems
___Ringing in Ears
___Vision Problems
___Double Vision
___Reduced Sense of Smell
___Reduced Sense of Taste
___Pain
___Headaches
___Lack of Energy
___Reduced Strength
___Tremor/Shakiness
___Involuntary or Repetitive Movements
___Reduced Motor Skills (using pencil, scissors, keys)
___Change in Handwriting
___Dizziness/Lightheadedness
___Nausea/Vomiting
___Constipation
___ Urinary or Bowel changes
___Sexual Dysfunction
___Problems with Sleep
___Change in Appetite
___Significant Loss/Gain in Weight
___Other:

Emotional Symptoms and Behavioral Difficulties: Please place a check in the space before the symptom(s) you are currently experiencing. If needed, provide additional details on a separate sheet.

___ Sadness/depression
___ Anger/irritability
___ Easily frustrated
___ Social withdrawal/isolation
___ Bizarre/strange feelings (voices, visions, skin sensations)
___ Hallucinations
___ Thoughts of harming yourself or another person
___ Anxiety/nervousness
___ Panic attacks
___ Phobias
___ Unusual behaviors
___ Impulsive/disinhibited
___ Speaking what comes to mind without filtering
Other:

Daily Functioning: For each of the following questions, please place a checkmark next to the description that best captures your abilities:

Activity		Current Ability Level
Using telephone		Able to look up numbers, dial telephone, and receive and make calls without help
		Able to answer telephone or dial operator in an emergency, but needs special telephone or help in getting numbers and/or dialing
		Unable to use telephone
Traveling		Able to drive own car or to travel alone on buses or in taxis
		Able to travel, but needs someone to travel with
		Unable to travel
Shopping		Able to take care of all food and clothes shopping with transportation provided
		Able to shop, but needs someone to shop with
		Unable to shop
Cooking		Able to plan and cook full meals
		Able to prepare light foods, but unable to cook full meals alone
		Unable to prepare any meals
Housework		Able to do heavy housework (i.e, scrub floors, lift laundry basket)
		Able to do light housework, but needs help with heavy tasks
		Unable to do any housework

Taking medicine		Able to prepare and take medications in the right dose at the right time
		Able to take medications, but needs reminding or someone to prepare them
		Unable to prepare or take medications
Managing $		Able to manage buying needs (i.e., write checks, pay bills)
		Able to manage daily buying needs, but needs help managing checkbook
		Unable to handle money
Driving		Unrestricted driving, no accidents/fender benders
		Limited to in town/daytime driving
		Have stopped driving

Health History: Please note whether you or any of your relatives have been diagnosed with any of the conditions listed below. If necessary, provide details about the condition on a separate sheet.

	Self (date diagnosed)	**Relative**		**Self** (date diagnosed)	**Relative**
Diabetes (Type I or Type 2)			Rheumatic fever		
Heart Disease/Artery Disease			Migraine		
High Cholesterol			Meningitis		
High Blood Pressure			Lyme Disease		
Heart attack			Concussion		
Heart surgery			Toxic exposures		
Thyroid/endocrine problems			Parkinson's disease		
Vitamin B12 deficiency			Alzheimer's disease		
Cancer, type:			Dementia		
type:			Multiple sclerosis		
Last Chemo/radiation:			Celiac disease		
Liver problems			Irritable bowel		
Kidney problems			Depression		
Epilepsy			Anxiety		
Allergies			Obsessive Compulsive Disorder		
Asthma			Bipolar disorder		
Stroke			Schizophrenia		
TIA/"mini stroke"			Other condition:		

Please list any surgeries you have had: _____

Please list, or attach on a separate sheet, all your current medications:

Medication	**Dosage**		**Medication**	**Dosage**

Substance Use:

Do you currently smoke? **Yes** **No**
Are you a former smoker? **Yes** **No**
If yes, when did you quit? _____

Do you currently drink alcohol? **Yes** **No**
If yes, how many drinks: ____/per night ____/per week
What is your drink of choice? _____

Was there a time when your use of alcohol was heavier? **Yes** **No**
Have you had problems due to your alcohol consumption? **Yes** **No**
(i.e., injuries, legal problems, family conflicts, work problems?)
Have you ever taken part in alcohol treatment? **Yes** **No**

Do you use, or have you ever used, marijuana? **Yes** **No**
Have you ever used any other drugs? **Yes** **No**
If yes, please specify:

To the best of my knowledge, the responses noted to the items in this background questionnaire are an accurate representation of my health and behavioral history.

_____

Patient Printed Name Signature Date