Memory & Psychological Services, Inc.

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NEUROPSYCHOLOGICAL TESTING BACKGROUND INFORMATION

Please answer all portions of this questionnaire completely.
Please use ink and print neatly. Thank you.

Name: _____ Date: _____

Home Phone: _____ Cell: _____

Age: _____ Date of Birth: _____ Gender: M [ ] F [ ]

Marital Status: _____ Dominant Hand: Right [ ] Left [ ]

Do you wear glasses or contacts? Yes [ ] No [ ]

Do you have difficulty hearing? Yes [ ] No [ ]

Do you wear a hearing aid? Yes [ ] No [ ]

Do you have difficulty smelling things? Yes [ ] No [ ]

What are your concerns?

_____

_____

_____

_____

_____

_____

_____

EDUCATIONAL HISTORY

Highest degree attained & area of study: _____

Year completed: _____ Grade point average: _____ GED? Yes [ ] No [ ]

Were you ever diagnosed with a learning disability? Yes [ ] No [ ]

If yes, describe: _____

Were you in special education or learning disabled classes? Yes [ ] No [ ]

Did you repeat any grades? Yes [ ] No [ ]

Did you have difficulty paying attention in school? Yes [ ] No [ ]

Were you hyperactive as a child? Yes [ ] No [ ]

Did you have trouble with your memory as a child? Yes [ ] No [ ]

WORK HISTORY

Name of Company **Dates of Employment** **Type of Work**

_____

_____

_____

_____

_____

_____

_____

Approximate last date of employment, if applicable: _____

Why did you stop working? _____

Current sources of income? _____

FAMILY MEDICAL HISTORY

Please indicate if anyone in your immediate family or a close relative has had any of the following conditions.

Neurological Disorders			**Relationship to the Patient**
Seizure Disorder	**Y [ ]**	**N [ ]**	_____
Dementia (unknown type)	**Y [ ]**	**N [ ]**	_____
Alzheimer's Disease	**Y [ ]**	**N [ ]**	_____
Parkinson's Disease	**Y [ ]**	**N [ ]**	_____
Huntington's Disease	**Y [ ]**	**N [ ]**	_____
Multiple Sclerosis	**Y [ ]**	**N [ ]**	_____
Stroke	**Y [ ]**	**N [ ]**	_____
Heart Disease	**Y [ ]**	**N [ ]**	_____
High Blood Pressure	**Y [ ]**	**N [ ]**	_____
Diabetes	**Y [ ]**	**N [ ]**	_____
Other _____	**Y [ ]**	**N [ ]**	_____

Psychiatric Disorders			**Relationship to the Patient**
Depression	**Y [ ]**	**N [ ]**	_____
Schizophrenia	**Y [ ]**	**N [ ]**	_____
Anxiety Disorder	**Y [ ]**	**N [ ]**	_____
Alcohol Abuse	**Y [ ]**	**N [ ]**	_____
Drug Abuse	**Y [ ]**	**N [ ]**	_____
Other _____	**Y [ ]**	**N [ ]**	_____

PATIENT'S MEDICAL/NEUROLOGICAL HISTORY

HEAD INJURY

Have you ever had a head injury? Y [ ] N [ ] If NO, you may skip this page; if YES, please fill out one section per head injury.

Approximate date of injury: ________________ Skull fracture? Y [ ] N [ ]

Did you lose consciousness? Y [ ] N [ ] For how long? _______________

Describe what happened: ____

Describe any problems you have (or had) with your thinking after this injury. (Such as language, memory, attention/concentration, or reasoning problems.)

____

____

Approximate date of injury: ________________ Skull fracture? Y [ ] N [ ]

Did you lose consciousness? Y [ ] N [ ] For how long? _______________

Describe what happened: ____

Describe any problems you have (or had) with your thinking after this injury. (Such as language, memory, attention/concentration, or reasoning problems.)

____

____

Approximate date of injury: ________________ Skull fracture? Y [ ] N [ ]

Did you lose consciousness? Y [ ] N [ ] For how long? _______________

Describe what happened: ____

Describe any problems you have (or had) with your thinking after this injury. (Such as language, memory, attention/concentration, or reasoning problems.)

____

____

STROKE

Have you ever had a stroke? Y [ ] N [ ] If NO, you may skip this page; if YES, please fill out one section per stroke.

Date of stroke: _______________ Location: Left [ ] Right [ ] Front [ ] Back [ ]

Did you lose consciousness? Y [ ] N [ ] For how long? ___________________

Describe what happened: ____

Any paralysis or weakness? Y [ ] N [ ] Where? ___________________________

Describe any problems you have (or had) with your thinking after the stroke. (Such as language, memory, attention/concentration, or reasoning problems.)

____

____

Date of stroke: _______________ Location: Left [ ] Right [ ] Front [ ] Back [ ]

Did you lose consciousness? Y [ ] N [ ] For how long? ___________________

Describe what happened: ____

Any paralysis or weakness? Y [ ] N [ ] Where? ___________________________

Describe any problems you have (or had) with your thinking after the stroke. (Such as language, memory, attention/concentration, or reasoning problems.)

____

____

Date of stroke: _______________ Location: Left [ ] Right [ ] Front [ ] Back [ ]

Did you lose consciousness? Y [ ] N [ ] For how long? ___________________

Describe what happened: ____

Any paralysis or weakness? Y [ ] N [ ] Where? ___________________________

Describe any problems you have (or had) with your thinking after the stroke. (Such as language, memory, attention/concentration, or reasoning problems.)

____

____

Please indicate whether you have been diagnosed with or experienced any of the following and the approximate dates of each.

Heart attack **Y [ ] N [ ]** **Date of onset:** _____

Anoxia **Y [ ] N [ ]** **Date of onset:** _____
(Low oxygen in the brain) **If yes, what happened?**

_____

Chronic Obstructive Pulmonary Disease (COPD) **Y [ ] N [ ]** **Date of onset:** _____

Hypertension **Y [ ] N [ ]** **Date of onset:** _____

Diabetes **Y [ ] N [ ]** **Date of onset:** _____

Liver disease **Y [ ] N [ ]** **Date of onset:** _____

Kidney disease **Y [ ] N [ ]** **Date of onset:** _____

Syphilis **Y [ ] N [ ]** **Date of onset:** _____

HIV/AIDS **Y [ ] N [ ]** **Date of onset:** _____

Cancer **Y [ ] N [ ]** **Date of onset:** _____

Where was it located? _____

Meningitis **Y [ ] N [ ]** **Date of onset:** _____

Encephalitis **Y [ ] N [ ]** **Date of onset:** _____

Seizures **Y [ ] N [ ]** **Date of onset:** _____

Frequency: Daily [ ] Weekly [ ] Monthly [ ] Other _____

Type: simple partial [ ] complex partial [ ] partial w/secondary generalization [ ] grand mal [ ] absence [ ] myoclonic [ ] clonic [ ] tonic [ ] atonic [ ]

Mark all that apply: convulsion [ ] loss of consciousness [ ] memory loss [ ] unusual sensations [ ] confusion [ ] falling [ ] limb stiffening [ ] limb jerking [ ]

Toxic solvent exposure Y [ ] N [ ] Date(s): _____

If yes, describe what happened:

_____

_____

Current medical diagnoses:

_____

_____

_____

Current medications:

Name	**Dose**	**Prescribed By**

Physicians:

Name	**Specialty**	**Phone Number**	**Fax Number**

****** PLEASE PROVIDE THE PHONE & FAX NUMBERS FOR EACH PHYSICIAN LISTED ABOVE ******

PSYCHIATRIC HISTORY

Have you had extended periods of time (more than 2 weeks) of feeling sad, blue, hopeless, helpless, or irritable? Y [ ] N [ ]

Approximate Date(s) **Duration** **Circumstances and symptoms**

_____

_____

_____

Have you had suicidal thoughts? Y [ ] N [ ]
If yes, how often?

_____

_____

Have you ever attempted suicide? Y [ ] N [ ]
If yes, when?

_____

_____

Have you had any extended periods of time of elevated mood (increased activity, no need for sleep, racing thoughts, spending sprees)? Y [ ] N [ ]

Approximate Date(s) **Duration** **Circumstances and symptoms**

_____

_____

_____

Have you had any episodes of violence in your lifetime? Y [ ] N [ ]

Approximate Date(s) **Duration** **Circumstances and symptoms**

_____

_____

_____

Have you ever been in jail? Y [ ] N [ ]

If yes, please give dates and describe reasons:

_____

_____

Have you ever heard voices that were not heard by others? Y [ ] N [ ]

Approximate Date(s) Duration Please describe

_____

_____

_____

Have you ever experienced a belief that there is a conspiracy against you, that you are being followed, or that your food is poisoned? Y [ ] N [ ]

Approximate Date(s) Duration Please describe

_____

_____

_____

Have you ever been hospitalized for psychiatric reasons? Y [ ] N [ ]

Approximate Date(s) Duration Facility or hospital

_____

_____

_____

SUBSTANCE USE HISTORY

Please list current alcohol use and number of alcohol equivalents (1 unit = 12 ounces beer, 5 ounces of wine, or a 1.25 ounce shot of hard liquor)

Drink _____ # per day _____ #per week _____ #per month _____

Drink _____ # per day _____ #per week _____ #per month _____

Drink _____ # per day _____ #per week _____ #per month _____

How old were you when you first drank? _____

How many years have you been drinking? _____

Have you ever had a drink in the morning? Y [ ] N [ ]

Have friends or family ever expressed concern about your drinking? Y [ ] N [ ]

Does this irritate you or make you angry? Y [ ] N [ ]

Have you ever had alcohol related black outs? Y [ ] N [ ] How many? _____

Have you ever been arrested for drunk driving? Y [ ] N [ ]

If you drank in the past, but have stopped:

When did you stop drinking? _____

Why did you stop drinking? _____

Have you ever been treated for alcohol or drug abuse? Y [ ] N [ ]

Dates of Treatment Name of Facility

_____

_____

Do you currently use illicit drugs or abuse prescription medication? Y [ ] N [ ]

If yes, please list in order of preference:

Drug _____ Daily [ ] Weekly [ ] Monthly [ ] Other _____

Drug _____ Daily [ ] Weekly [ ] Monthly [ ] Other _____

Drug _____ Daily [ ] Weekly [ ] Monthly [ ] Other _____

How many years have you been using/abusing? _____ Age started? _____

PATIENT SYMPTOMS

Please indicate if any of these symptoms have occurred and list dates of onset. If you listed these in an earlier section, there is no need to report them again.

Paralysis Y [ ] N [ ] Date of Onset _____

If yes, which limbs and for how long? _____

Loss of Sensation Y [ ] N [ ] Date of Onset _____

If yes, which limbs and for how long? _____

Gait Disturbance Y [ ] N [ ] Date of Onset _____
Describe:
_____

Headache Y [ ] N [ ] Date of Onset _____
Describe:
_____

Visual Disturbance Y [ ] N [ ] Date of Onset _____
Describe:
_____

Loss of Smell or Taste Y [ ] N [ ] Date of Onset _____
Describe:
_____

Change in Appetite Y [ ] N [ ] Date of Onset _____
Describe:
_____

Sleep Disturbance Y [ ] N [ ] Date of Onset _____
Describe:
_____

Attention/Concentration Problems Y [ ] N [ ] Date of Onset _____
Describe:
_____

Memory Problems Y [ ] N [ ] Date of Onset _____
Describe:
_____

Reasoning/Judgment Problems Y [ ] N [ ] Date of Onset _____
Describe:
_____

Organization Problems Y [ ] N [ ] Date of Onset _____
Describe:
_____

Language Problems Y [ ] N [ ] Date of Onset _____
Describe:
_____

COGNITIVE DIFFICULTIES

Please check all that you have difficulty with:

[ ] Fixing things you used to be able to repair
[ ] Starting activities (initiation)
[ ] Completing something you started (because you forgot what you were doing)
[ ] Planning and organizing daily activities
[ ] Needing frequent reminders from others
[ ] Needing to rely on reminder notes
[ ] Finding that reminders do not help
[ ] Remembering directions or easily getting lost
[ ] Keeping track of what people are saying to you
[ ] Remembering what people have said to you after some time has elapsed
[ ] Remembering what you have read
[ ] Following the plot in a movie or book
[ ] Remembering what you have seen on television
[ ] Remembering to convey telephone messages
[ ] Remembering to keep appointments
[ ] Remembering to take medication
[ ] Remembering to pay bills
[ ] Remembering to turn off the stove or faucet
[ ] Remembering where you put something
[ ] Remembering tasks related to your work (describe) _____

How did these cognitive changes happen? Suddenly [ ] Gradually [ ]

If gradual, over what period of time? _____

How have your cognitive problems changed over time?

_____

_____

Did your cognitive problems begin only after you first felt depressed or anxious?
Y [ ] N [ ]

Do you experience cognitive problems when you are not depressed or anxious?
Y [ ] N [ ]

FAMILY AND PERSONAL BACKGROUND

Who did you grown up with (mother, father, sisters, brothers)? _____

_____

Marital Status: _____ If married, for how long? _____

Number of marriages _____ # of natural children _____ # of step children _____

Who are you currently living with? _____

_____

Do you have any relatives or friends who you keep in touch with and who can help you out? Y [ ] N [ ]

If yes, who? _____

Do you need assistance with tasks around the house or with personal care such as dressing, bathing, shopping, or meal preparation? Y [ ] N [ ]

If yes, please describe: _____

_____

Are you receiving this assistance? Y [ ] N [ ]

Is the level of assistance you are receiving enough? Y [ ] N [ ]

How do you like to spend your free time? _____

_____

_____

Have you had any difficulty driving? Y [ ] N [ ]

If yes, please describe: _____

_____

Have you have any recent fender benders or accidents? Y [ ] N [ ]

If yes, please describe: _____

_____