Adult Neuropsychological Questionnaire

Note: If you need more space for any of the answers, please use the back page(s) to elaborate.

Name:_____ Date of Birth:_____
Age:_____ Sex:_____ Highest Grade/Degree Completed:_____
Dominant Hand ○ R ○ L ○ Ambidextrous
Native Language: _____ Cultural identity: _____

Reason for seeking this evaluation:

- ☐ **Concussion**- continue to section A
- ☐ **Other**- briefly describe here and then skip to Section B:

Section A

Concussion/brain injury history

When was most recent concussion?_____
Briefly how did it occur?_____
Did you lose consciousness?_____If yes, for how long?_____
Did you have amnesia for a period of time prior to the injury?_____If yes, for how long?_____
Did you have amnesia for a period of time following the injury? _____If yes, for how long?_____
Were you taken to the hospital?_____Did you have a CT scan?_____An MRI?_____
What were the diagnoses and results of any imaging?_____
How have you been feeling since then?_____

List all other concussions and other (possible) brain injuries (LOC= Loss of consciousness)

Year/Age	Cause	LOC? ✔	Amnesia? ✔	Other symptoms	How long to recover?
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		

Section B

Other Medical/Health History

Do you have the following or a history of the following? (Check all that apply)	Current ✔	Past history of…✔	Specifics…
Birth trauma	☐	☐	
Huntington's Disease	☐	☐	
Spina Bifida	☐	☐	
Cerebral Palsy	☐	☐	
Learning Disability	☐	☐	
ADHD/ADD	☐	☐	

Vision problems	☐	☐	
Eating disorder	☐	☐	
Speech problems	☐	☐	
Hearing problems	☐	☐	
Frequent ear infections	☐	☐	
Asthma, COPD, other respiratory disorder	☐	☐	
Seizure Disorder	☐	☐	
Cancer	☐	☐	
Thyroid Condition	☐	☐	
Meningitis or Encephalitis (specify)	☐	☐	
Spinal cord injury	☐	☐	
Stroke, cerebrovascular disease, TIAs	☐	☐	
Heart Disease	☐	☐	History of heart attack?
Hypertension (high blood pressure)	☐	☐	
Dyslipidemia, High cholesterol	☐	☐	
Migraines	☐	☐	Frequency: Duration:
Headaches	☐	☐	Frequency: Duration:
Diabetes	☐	☐	
Multiple sclerosis	☐	☐	
Systemic Lupus	☐	☐	
Dementia	☐	☐	
HIV+/ AIDS	☐	☐	
Hepatitis or other liver disease	☐	☐	Specify: A☐ B☐ C☐
Toxic Exposure (e.g., lead, carbon monoxide)	☐	☐	When? What:
Lyme Disease or other tick borne disease	☐	☐	
Parkinson's Disease	☐	☐	
Arthritis	☐	☐	
Fibromyalgia or other chronic pain	☐	☐	
Sleep apnea	☐	☐	CPAP use?
Heavy snoring or waking to catch breath	☐	☐	
Other sleep disorders	☐	☐	
Excessive daytime fatigue	☐	☐	
Unexplained weight gain or weight loss	☐	☐	
Gastrointestinal disorder	☐	☐	
Depression	☐	☐	
Anxiety problems	☐	☐	
OCD, panic disorder, agoraphobia	☐	☐	
Tourette's or other tic disorder	☐	☐	
Bipolar Disorder "manic depression"	☐	☐	
Schizophrenia or Schizoaffective disorder	☐	☐	
Abuse or neglect	☐	☐	Ages:
Posttraumatic Stress Disorder	☐	☐	Age: Cause:
Postpartum depression	☐	☐	When?
Alcoholism	☐	☐	Sober? For how long?
Drug abuse or dependence	☐	☐	
Autism spectrum disorder (e.g., Aspergers)	☐	☐	

Mental Retardation/Intellectual Disability	☐	☐	
Neurofibromatosis	☐	☐	
Neuromuscular disease	☐	☐	
Concussions/head injury/brain injury	☐	☐	

List Allergies:_____

List all surgeries and year of procedure (use last page if necessary):

_____

List other recent illnesses/injuries:_____

List date & results of brain scans (e.g., MRI or CT) and EEG not already described above:

_____

Do you normally exercise? (Describe frequency and type):_____

Typical amount of sleep per night_____ Quality of sleep_____

Biological Mother: Present age ____ Years of education ____ Occupation _____

If deceased, age at death and cause of death _____

Biological Father: Present age ____ Years of education ____ Occupation _____

If deceased, age at death and cause of death _____

Biological Full or Half Siblings: First names, present ages, health problems:

_____

Family Medical History: Check any conditions experienced by family members and note who:

☐ Dementia ☐ Heart Disease ☐ Stroke/TIAs

☐ Alcoholism ☐ Drug Abuse ☐ Cancer- Types: _____

☐ Depression ☐ Anxiety ☐ Other mental illness:_____

☐ ADD/ADHD ☐ Learning Disability ☐ Seizure Disorder ☐ Migraines

☐ Other Neurologic (e.g., MS, Parkinsons):_____

☐ Other Mental Health:_____

Primary Care Provider: _____

Other Providers involved in care:_____

Substance Use	How often/How much per day	How often/How much per week	✔ if prior problem but not current
Caffeine (coffee, tea, soda, sports drinks)			☐
Alcohol			☐
Marijuana (including medical)			☐
Nicotine/Tobacco (smoked, chewed, vaped)			☐
Other (e.g., cocaine, opiate misuse, inhalants...)			☐

Section C
Childhood History
Briefly describe your family and growing up experience:

Your Prenatal and Birth History:
Age of mother when you were born: _____Age of father when you were born:_____

	No	Yes	Comments
Are you a twin, triplet or other multiple?	○	○	
Any problems with this pregnancy?	○	○	
Toxin exposure during pregnancy? (e.g., lead, nicotine, alcohol, cocaine, other drugs- specify)	○	○	
Any problems during labor and delivery?	○	○	
Cesarean (c-section) Delivery?	○	○	
Born premature?	○	○	
Born late?	○	○	

Your Infant and Early Developmental History

	No	Yes	Comments
Any problems at birth or as a newborn? APGAR score?	○	○	
Cord around neck? Blue? Not breathing? Underdeveloped lungs?	○	○	
Required Intensive Care? If yes, how many days?	○	○	
Any developmental delays (e.g., speech, motor)	○	○	

Part D
Educational and Work History

Did you receive Special Education? _____ When Started? _____Ended?_____

Did you repeat any grades? Which? Why? _____

Best Subject/s?_____ Hardest Subject/s?_____

Average Grades Elementary?_____High School?_____

High School Diploma?_____ Year completed _____ Or, highest grade completed:_____

GED? _____ SAT scores_____ GREs/LSATs/MCATs/GMATs_____

College? Y/N- Name, degree and year of degree_____

Graduate School? Y/N- Name, degree and year of degree_____

What is your occupation or usual type of work?_____

Present or most recent job: Title _____ Employer _____

Dates worked _____ if no longer there, reason for leaving _____

Previous job: Title _____ Employer _____

Dates worked _____ Reason for leaving _____

Previous job: Title _____ Employer _____

Dates worked _____ Reason for leaving _____

Did /do you generally enjoy your work?_____

Did/do you get positive job evaluations?_____

Problems at work currently?_____

If not currently working, why not, and what would you like to be doing?

_____

Military Service

Branch _____ Years served_____ Job/s_____

Highest Rank _____ Type of Discharge_____Combat (zone)? ◯Y ◯N

Part E

Legal History

Ever been arrested (include OUI)?___ Describe_____

Currently involved in any lawsuits or legal actions? _____ Describe _____

Do you have any problems driving?___ Describe_____

Part F

Adult Family and Social History

Current relationship status:_____If relevant, years together_____Children?_____

Quality of current relationship (e.g., supportive/healthy versus conflicted/strained?

_____

Current members of household

_____

What are your non-work activities?

_____

Are you satisfied with your social life/friends?_____

Please indicate date form was completed_____and anyone who helped with the completion of the form (and relationship to patient)_____

Please bring a list of current medications and supplements at the time of your appointment. Include dose and frequency.
Thank you!

Use this page to expand on your answers if there was not enough room for doing so on the form. Please indicate the question on which you are elaborating.