Please note that this form does not need to be completed prior to your first appt. You may begin to complete it while you're waiting to be called, but the provider will give you time to finish the form during your session.

Department of Physical Medicine and Rehabilitation
Neuropsychology Clinic
Treating Provider: Amy Martinez, Psy.D.

Neuropsychological Evaluation Adult Questionnaire

Please Print:

Please fill out the following form as thoroughly as you can. This form is used to expedite the evaluation process and provides your doctor with important information used to determine the best medical and psychological treatment for you. If you feel unable to answer any questions, simply skip those and let the clinician know when you meet with him or her. ***(Please return this form to Dr. Martinez).***

Patient Name:_____ Phone Number:_____

Patient Address:_____

Date of Birth:_____ Age:_____

Are you right or left handed?: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Education (years completed):_____ Highest Degree_____

Gender: ☐ Male ☐ Female

Ethnicity: ☐ Caucasian ☐ Latino(a) ☐ Chicano(a) ☐ Native-American
☐ African-American ☐ Asian-American ☐ Bi/Multiracial ☐ Other

Primary Language(s) Spoken In the Home:

_____

Date of Injury (if applicable):_____

Today's Date:_____

Questionnaire Completed By:_____ Relationship to Patient:_____

Primary Care Doctor:_____ Phone Number:_____

Referring Physician:_____ Phone Number:_____

Employer:_____

HISTORY OF PRESENT ILLNESS:

Describe any medical problems that you *currently* experience (please be specific):

1._____

2._____

3._____

4._____

5._____

Please list any medical tests or screenings you have received (EEG, EKG, PET, MRI, CT scan, X-ray etc.) related to your illness/injury (please provide results and approximate dates):

TEST	RESULT	DATE

Please list any medications you are currently taking (include herbal remedies, over-the-counter medicines, and prescription medicines):

MEDICINE	DOSE	WHEN TAKEN	WHAT FOR

Briefly describe your accident and/or injury (if applicable):

_____

_____

_____

_____

_____

_____

Describe you and your doctor's reasons for requesting this neuropsychological evaluation:

_____

_____

_____

_____

_____

Please compare your present status to your preinjury/preillness status on the following questions:

Appetite

☐ A. No change since injury/illness
☐ B. Mild increase since injury/illness
☐ C. Moderate/Marked increase since injury/illness
☐ D. Decreased since injury/illness

If answer is B, C, or D has there been any weight gain or loss? ☐ YES ☐ NO

If yes, please indicate amount of: pounds gained_____ or pounds lost_____

Sleeping

☐ A. No change since injury/illness
☐ B. Mild decline since injury/illness
☐ C. Moderate/Marked decline since injury/illness
☐ D. Mild increase since injury/illness
☐ E. Moderate/Marked increase since injury/illness
☐ F. Sleep disturbance

Energy Level

☐ A. No change since injury/illness
☐ B. Mild decline since injury/illness
☐ C. Moderate/Marked decline since injury/illness
☐ D. Mild increase since injury/illness
☐ E. Moderate/Marked increase since injury/illness

Feelings of Depression

☐ A. None
☐ B. Present before and after injury to about the same degree
☐ C. Mild increase since injury/illness
☐ D. Moderate/Marked increase since injury/illness
☐ E. Less pronounced since injury/illness

Feelings of Anxiety

☐ A. No change since injury/illness
☐ B. Mild decline since injury/illness
☐ C. Moderate/Marked decline since injury/illness
☐ D. Mild increase since injury/illness
☐ E. Moderate/Marked increase since injury/illness

Patience

☐ A. No change since injury/illness
☐ B. Mild decline since injury/illness
☐ C. Moderate/Marked decline since injury/illness
☐ D. Mild increase since injury/illness
☐ E. Moderate/Marked increase since injury/illness

Temper/Impulse Control

☐ A. No change since injury/illness
☐ B. Worse since injury/illness
☐ C. Better since injury/illness

Seeing, Hearing, or Sensing Touch For Things That Other People Don't See, Hear, or Sense

☐ A. None
☐ B. Hearing (voices, strange sounds)
☐ C. Seeing (images, flashbacks)
☐ D. Sensing Touch (feeling things on your skin)

If B, C, or D please explain below:

_____

_____

Dizziness

☐ A. Not present now or before
☐ B. Mild increase since injury/illness
☐ C. Moderate/Marked increase since injury/illness
☐ D. Decrease since injury/illness

Coordination

☐ A. No change since injury/illness
☐ B. Mild decrease since injury/illness
☐ C. Moderate/Marked decrease since injury/illness
☐ D. Improved since injury/illness

Headaches

☐ A. None
☐ B. No increase in frequency or type (same as before injury/illness)
☐ C. Increase in frequency and/or type, but not interfering with daily activities
☐ D. Increase in frequency and/or type and interfering with daily activities

Vision

☐ A. No change since injury/illness
☐ B. Mild disturbance since injury/illness
☐ C. Moderate/Marked disturbance since injury/illness
☐ D. Improved since injury/illness

Hearing

☐ A. No change since injury/illness
☐ B. Mild disturbance since injury/illness
☐ C. Moderate/Marked disturbance since injury/illness
☐ D. Improved since injury/illness

Taste and Smell

☐ A. No change since injury/illness
☐ B. Mild disturbance since injury/illness
☐ C. Moderate/Marked disturbance since injury/illness
☐ D. Improved since injury/illness

Has your sense of touch changed since the injury/illness?

☐ YES ☐ NO (If yes, please explain below)

_____

_____

Concentration

☐ A. No change since injury/illness
☐ B. Mild decline since injury/illness
☐ C. Moderate/Marked decline since injury/illness
☐ D. Improved since injury/illness

Recent Memory (e.g. remembering appointments, finding keys etc.)

☐ A. No change since injury/illness
☐ B. Mild decline since injury/illness
☐ C. Moderate/Marked decline since injury/illness
☐ D. Improved since injury/illness

Distant Memory (e.g. remembering childhood, remembering things learned in school etc.)

☐ A. No change since injury/illness
☐ B. Mild decline since injury/illness
☐ C. Moderate/Marked decline since injury/illness
☐ D. Improved since injury/illness

Visual Memory (e.g. remembering faces, how to get to places etc.)

☐ A. No change since injury/illness
☐ B. Mild decline since injury/illness
☐ C. Moderate/Marked decline since injury/illness
☐ D. Improved since injury/illness

Please describe below any other changes you have noticed since your injury/illness:

_____

_____

_____

PAST MEDICAL HISTORY:

Please place a checkmark next to all treatments that you have had up to this point:

☐ Biofeedback	☐ Pool Therapy	☐ Occupational Therapy
☐ Acupuncture	☐ Injections	☐ Pain Medications
☐ Psychotherapy/Counseling	☐ Psychiatric Medications	☐ Massage
☐ Chiropractic Manipulation	☐ Osteopathic Manipulation	☐ Surgery
☐ Nutritional/Diet Consultation	☐ Physical Therapy	☐ Rehabilitation Therapy

Please list any additional treatments you have had not listed above:

_____

_____

Please list briefly any surgeries you have had and approximate dates.

SURGERY/PROCEDURE DATE

1._____

2._____

3._____

4._____

5._____

What treatments for your current illness/injury have been beneficial and why?

_____

_____

What treatments have made you feel worse and why?

NEUROLOGICAL HISTORY:

Is there a history of emotional or neurological illness in your family (i.e. Parkinson's, Alzheimer's, Multiple Sclerosis, Depression, Anxiety, Schizophrenia etc.)?

☐ YES ☐ NO (if yes, please describe below and the family member having the illness)

Do you have any history of a neurological disease or disorder (i.e. Parkinson's, Alzheimer's, Multiple Sclerosis, Encephalitis, Alcohol Dementia, Epilepsy etc.)?

☐ YES ☐ NO (if yes, please describe below)

Do you ***currently*** have an injury to the head, neck, or spine? ☐ YES ☐ NO

(if yes, please describe below)

Have you ever ***previously*** had an injury to the head, neck, or spine? ☐ YES ☐ NO

(if yes, please describe below and list approximate dates)

Have you ever had a loss of consciousness? ☐ YES ☐ NO

If you answered "yes" to the question above, for how long did you lose consciousness?

☐ 1-5 minutes ☐ 5-10 minutes ☐ 10-30 minutes ☐ 30-60 minutes ☐ >than 60 minutes

Do you have a history of seizures? ☐ YES ☐ NO (if yes, please describe below)

Do you have a problem with headaches? ☐ YES ☐ NO (if yes, please describe below)

_____

_____

PSYCHIATRIC HISTORY:

Please put a checkmark next to any problems you *currently* are experiencing or have *ever* experienced (circle problems that pertain to you if there is more than one choice):

☐ Worry/Nervousness/Fears	☐ Nightmares/Flashbacks	☐ Thoughts of Hurting Myself
☐ Low Energy/Sadness/Guilt	☐ Seeing Things That Others Say Are Not There	☐ Thoughts of Hurting Someone Else
☐ Addiction/Substance Abuse	☐ Beliefs That Others View As Strange	☐ Racing Thoughts/Excessive Energy
☐ Problems with Concentration/Attention	☐ Problems with Memory/Forgetfulness	☐ Outbursts/Short Temper

Have you ever had any mental health treatment? (i.e. medications, counseling, psychotherapy)

☐ YES ☐ NO (if yes, please describe below when, where, by whom, and reason)

_____

_____

_____

_____

_____

Have you ever been hospitalized for mental health reasons?

☐ YES ☐ NO (if yes, please describe below, including when, where, by whom and reason)

_____

_____

_____

_____

_____

Are you currently taking any medications to help with emotional or psychiatric problems?

☐ YES ☐ NO (if yes, please describe below, including dosages and times you take them)

1. _____DOSE_____TIME TAKEN_____

2. _____DOSE_____TIME TAKEN_____

3. _____DOSE_____TIME TAKEN_____

SUBSTANCE USE HISTORY:

Do you currently smoke cigarettes, cigars, pipe, or chew tobacco?

☐ YES ☐ NO (if yes, please describe below how much and for how long)

_____

_____

How much alcohol do you drink on a weekly basis? (i.e. number of drinks, beers, pints, etc.)

_____

_____

_____

Have you ever worried about your drinking or has someone else expressed concern about your drinking? ☐ YES ☐ NO (if yes, please describe below)

_____

_____

_____

Do you currently use recreational drugs? (pot, acid, ecstasy, cocaine, heroin etc.)

☐ YES ☐ NO (if yes, please describe below)

_____

_____

_____

Have you ever tried recreational drugs? (pot, acid, ecstasy, cocaine, heroin etc.)

☐ YES ☐ NO (if yes, please describe below)

_____

_____

_____

Does anyone in your family have a problem with drugs or alcohol?

☐ YES ☐ NO (if yes, please describe below)

_____

_____

_____

LEGAL HISTORY:

Do you currently have any legal problems?

☐ YES ☐ NO (if yes, please describe below)

_____

_____

_____

Is there a law suit pending that is associated with your current injury or illness?

☐ YES ☐ NO (if yes, please describe below)

_____

_____

_____

Have you ever been arrested before?

☐ YES ☐ NO (if yes, please describe below)

_____

_____

Were you ever convicted of a crime or did you ever spend time in prison?

☐ YES ☐ NO (if yes, please describe below)

_____

_____

Do you currently have an attorney?

☐ YES ☐ NO (if yes, please indicate the attorney's name, phone number and address below)

Attorney's Name:_____

Phone Number:_____

Address:_____

BACKGROUND / FAMILY HISTORY:

Are you currently employed? ☐ YES ☐ NO (If yes, please describe where and for how long.)

_____

_____

_____

If yes, what is your job title and what are your responsibilities? (Please describe briefly below)

_____

_____

If no, is unemployment a result of the injury? ☐ YES ☐ NO

How long have you been out of work? _____

What is your current relationship status? (please check one)

☐ Single ☐ Living Together ☐ Married/Same Sex Partner ☐ Separated ☐ Divorced ☐ Widowed

Do you have any children from your current marriage/relationship or previous marriages/relationships?

☐ YES ☐ NO (If yes, please describe below with names, ages etc.)

_____

_____

_____

Please list any significant family medical problems (i.e. diabetes, high blood pressure, cancer, stroke, heart disease etc.)

_____

_____

Where were you born?

_____

_____

If not born in this area, how did you end up here?

_____

_____

Do you have any brothers or sisters?

☐ YES ☐ NO (if yes, how many and what age currently?)

_____

_____

_____

_____

What number child are you?_____

Do you currently have a good relationship with your family?

☐ YES ☐ NO

Did your parents stay married?

☐ YES ☐ NO

(If no, how old were you when they divorced and with whom did you live after the divorce?)

_____

_____

_____

_____

Please briefly describe your childhood:

_____

_____

_____

_____

_____

_____

Was there any abuse growing up?

☐ YES ☐ NO (if yes, please check appropriate boxes below)

☐ Physical ☐ Emotional ☐ Sexual

DEVELOPMENTAL HISTORY:

Were you adopted? ☐ YES ☐ NO

If yes, do you know your biological mother's history? ☐ YES ☐ NO

If yes, please fill out the section's below as it pertains to your biological mother.

Did your mother take any medication while she was pregnant?

☐ YES ☐ NO ☐ DON'T KNOW (If yes, please describe below)

_____

_____

Did your mother smoke while she was pregnant?

☐ YES ☐ NO ☐ DON'T KNOW (If yes, please describe below)

_____

_____

Did your mother drink alcohol while she was pregnant?

☐ YES ☐ NO ☐ DON'T KNOW (If yes, please describe below)

_____

_____

Did your mother use recreational drugs while she was pregnant?

☐ YES ☐ NO ☐ DON'T KNOW (If yes, please describe below)

_____

_____

Were there any problems during your mother's pregnancy with you?

☐ YES ☐ NO ☐ DON'T KNOW (If yes, please describe below)

_____

_____

Did your mother have any problems with your birth? (i.e. were you born premature, breach, late, c-section?)

☐ YES ☐ NO ☐ DON'T KNOW (If yes, please describe below)

_____

_____

Please put a checkmark next to any problems that describe your experiences *as a child*:

- ☐ Delay learning to walk
- ☐ Delay learning to talk
- ☐ Delay learning to read
- ☐ Behavioral problems at school
- ☐ Bedwetting
- ☐ Nail Biting
- ☐ Difficulty paying attention
- ☐ Memory problems
- ☐ Depressed
- ☐ Aggressive
- ☐ Shy
- ☐ Tantrums
- ☐ Nightmares
- ☐ Poor self-esteem
- ☐ Unpredictable
- ☐ Cried easily and often
- ☐ Acted young for your age
- ☐ Became frustrated easily
- ☐ Excitable
- ☐ Stubborn
- ☐ Poor coordination
- ☐ Hyperactive
- ☐ Blank or staring spells
- ☐ Difficulty making friends
- ☐ Impulsive
- ☐ Disorganized
- ☐ Difficulty controlling emotions
- ☐ Daydreams often
- ☐ Easily distracted
- ☐ Trouble sitting still
- ☐ Difficulty finishing projects
- ☐ Attention wandering
- ☐ Slow reader
- ☐ Problems with math
- ☐ Poor penmanship
- ☐ Difficulty writing/spelling

Please use the spaces provided below to add any additional information or describe other problems areas for you <u>*as a child*</u>:

_____

_____

_____

EDUCATIONAL / ACADEMIC HISTORY:

Did you graduate from High School or obtain a GED?

☐ YES ☐ NO

What were grades like in High School? (i.e. A's, B's, C's, D's)

_____

How many years of school have you had (e.g. GED=12, High School=12, Associates Degree=14, Bachelors Degree=16, etc.)?

_____

If you went to college or graduate school, what did you study?

_____

What degree did you attain (i.e. B.A., M.A., Ph.D. etc.)

_____

Have you attended any technical school or training (vocational, computers, mechanic, etc.)?

☐ YES ☐ NO (If yes, please describe below)

_____

_____

Were you ever held back in school?

☐ YES ☐ NO (If yes, please describe below)

_____

_____

Did you have difficulties with any particular subject? (i.e. math, spelling, reading, etc)

☐ YES ☐ NO (If yes, please describe below)

_____

_____

Were you ever diagnosed with a learning disability?

☐ YES ☐ NO (If yes, please describe below)

_____

_____

STRESSORS:

Please check all the items that are currently areas of stress in your life:

☐ Spouse/Family ☐ Occupational/Work ☐ Health Access/Insurance

☐ Friends/Social ☐ Housing/Living Situation ☐ Legal System/Crime

☐ Educational/School ☐ Economic/Financial ☐ Other_____

Please describe your areas of stress more thoroughly below:

_____

_____

_____

_____

_____

What is your support system like? (family, friends, groups, church, etc.)

_____

_____

_____

_____

_____

Are friends/family/etc. available for you and willing to discuss your current problems?

☐ YES ☐ NO (Please describe below)

_____

_____

_____

Congratulations, you've reached the end of the questionnaire! Thank you for taking the time to complete this important piece of documentation. Dr. Martinez will discuss your responses with you and allow you time to ask any questions you might have about your neuropsychological evaluation.