dr. taylor

NEUROPSYCHOLOGY

Adult Questionnaire

Please answer the following questions carefully and completely. Your answers will help us greatly in our understanding of your background and history. You will have the option to discuss your responses further, should you wish, during your feedback appointment.

Date: _____

Patient Name: _____ Gender: _____

Age: _____ Date of Birth: _____ Handedness: ☐ Right ☐ Left

PSYCHOLOGICAL HISTORY

Where were you born?_____
Mother's name:_____ Occupation:_____
Father's name:_____Occupation:_____

Do you have siblings? Yes No # of Brothers: _____ # of Sisters: _____

Were your parents living together throughout your childhood? Yes No
If no, were your parents:

☐ Divorced ☐ Never married ☐ Death of parent (circle): Mother Father

How would you describe your childhood? (Check all that apply):

☐ Happy ☐ Normal ☐ Lonely ☐ Troubled ☐ Difficult
☐ Idyllic ☐ Calm ☐ Sad ☐ Fearful ☐ Deprived

Other (please describe):_____

Did you experience any traumas, tragedies, or abuse? Yes No
If yes, please check all that apply:

☐ Death of Parent ☐ Other Deaths ☐ Physical Abuse ☐ Sexual Abuse
☐ Family Violence ☐ Neglect ☐ Other (please describe):_____

_____

Were you involved with a chronically or seriously ill person while growing up? Yes No

If yes, please describe: _____

_____

_____

_____

_____

_____

SOCIAL INFORMATION

Marital Status:

☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Co-habiting

If single, how long have you lived alone? _____

If co-habiting, how long have you lived together? _____

If married, please state number of marriages and years together: _____

_____

How is your partners health? Good Fair Poor

Please list partner's health problems, if any: _____

_____

Current Address: _____

_____

Please list the names of any people currently living in your household and your relationship:

Name: _____ Relation: _____
Name: _____ Relation: _____
Name: _____ Relation: _____
Name: _____ Relation: _____
Name: _____ Relation: _____
Name: _____ Relation: _____

If applicable, please list the name(s) of any of your children not living with you:

Name: _____ City & State Residing: _____ Age: _____
Name: _____ City & State Residing: _____ Age: _____
Name: _____ City & State Residing: _____ Age: _____
Name: _____ City & State Residing: _____ Age: _____
Name: _____ City & State Residing: _____ Age: _____

EDUCATION

How would you describe your grades?

☐ Excellent ☐ Above Average ☐ Average ☐ Poor ☐ Failing

Last school grade completed:_____ Degree(s) Received:_____

Did you have any learning problems in school? Yes No

If yes, please describe:_____

_____

If yes, did you receive any education services? Yes No

If you left school before graduation, please explain why:

_____

_____

If applicable, please describe any special training or education you received:

_____

_____

WORK HISTORY

Occupation:_____

Are you retired? Yes No If yes, since when:_____

Type: ☐ Voluntary ☐ Medical

Are you disabled? Yes No

If yes, since when and what caused the disability:_____

_____

Do you receive Social Security benefits? Yes No

Do you receive Private Disability benefits? Yes No

Do you have a work related lawsuit? Yes No

If yes, please name your lawyer and describe the lawsuit: _____

_____

_____

Please list your last several jobs:

Position: _____ Employer: _____

Approximate dates of employment: _____

Position: _____ Employer: _____

Approximate dates of employment: _____

Position: _____ Employer: _____

Approximate dates of employment: _____

MEDICAL HISTORY

Please list any serious illnesses you currently have or have had in the past as well as the date(s):

Please list your current medication(s) as well as the dosage, frequency taken, and for how long you've been on specified medication(s):

Please list any previous hospitalizations/operations:

Condition: _____
Date:_____ Hospital: _____
Condition: _____
Date:_____ Hospital: _____
Condition: _____
Date:_____ Hospital: _____
Condition: _____
Date:_____ Hospital: _____

Indicate whether you have previously had any of the following tests or evaluations done, if so, please state when. (Example: b - June 2018):

(a) *MRI Scan,* ***(b)*** *CAT Scan,* ***(c)*** *EEG Test,* ***(d)*** *Carotid Doppler Test,* ***(e)*** *Neuropsychological Evaluation*

Have you ever had any mental health concerns? Yes No

If yes, did you receive treatment? Yes No

If yes, please denote from whom, when, and for what problem:

Have you ever been prescribed antidepressant or anti-anxiety medication? Yes No
If yes, please denote what medicine, who prescribed, and when:

_____

_____

Please list if anyone in your extended family has had any medical or mental health diagnoses such as: depression, ADHD, learning disorder, autism, etc.

Relation:_____ Diagnoses:_____
Relation:_____ Diagnoses:_____
Relation:_____ Diagnoses:_____
Relation:_____ Diagnoses:_____
Relation:_____ Diagnoses:_____

Have you ever had vision problems? Yes No

- Glasses: Yes No
- Glaucoma: Yes No Right Eye Left Eye
- Blurring: Yes No Right Eye Left Eye
- Double vision: Yes No
- Other (please specify):_____

Have you ever had hearing problems? Yes No

- Hearing aids: Yes No Right Ear Left Ear
- Ringing: Yes No Right Ear Left Ear
- Buzzing: Yes No Right Ear Left Ear
- Other (please specify):_____

Have you ever heard or seen things that others have not? Yes No
If yes, please describe: _____

_____

_____

Have you ever had any ***head injuries*** when you lost consciousness? Yes No
If yes, describe incident(s) and length of time unconscious:_____

_____

_____

Have you experienced ***episodes*** where you blacked out, fainted or lost consciousness? If yes, describe incident & duration unconscious: Yes No

_____

_____

Do you currently or have you ever had high blood pressure? Yes No

Do you currently or have you ever had seizures? Yes No

If yes, denote type, frequency, and duration:

Do you have frequent headaches? Yes No

If yes, describe severity, frequency, and duration:

Do you have balance problems? Yes No

If yes, please describe:

Do you have urinary incontinence? Yes No

If yes, please describe:

Do you have weakness in any part of your body? Yes No

If yes, please describe:

Do you experience numbness in any part of your body? Yes No

If yes, please describe

Have you ever been involved in a motor vehicle accident? Yes No

If yes, please describe:

Have you *recently* experienced any changes in weight? Yes No

If yes, please indicate severity: Mild Moderate Severe

Have you *recently* experienced any changes in appetite? Yes No

If yes, please indicate severity: Mild Moderate Severe

Have you felt depressed within the *last two weeks*? Yes No

If yes, please indicate severity: Mild Moderate Severe

Please describe your sleep pattern:

Have you smoked cigarettes in the past? Yes No

If yes, please indicate severity: Mild Moderate Severe

Do you smoke cigarettes currently? Yes No

Have you used alcohol in the past? Yes No

If yes, please indicate severity: Mild Moderate Severe

Do you drink alcohol currently? Yes No

Do you use recreational drugs currently? Yes No

If yes, please describe type, for how long, and frequency:

Have you used recreational drugs in the past? Yes No

If yes, please describe type, for how long, and frequency:

Have you ever overused prescription medication to relieve pain or distress? Yes No

If yes, please describe type, for how long, and frequency:

Please use this space to describe any other significant events in your childhood or later life you would like Dr. Taylor to know about:

Thats it, you've made it to the end! Thank you for taking the time to complete this questionnaire. Your input is greatly appreciated!

Shannon E. Taylor PhD.
Licensed Clinical Psychologist