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 (Circle): 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 you <u>did</u> experience any traumas, tragedies, or abuse, 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 partner's 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 any previous hospitalizations/operations:

Condition: _____

Date:_____ Hospital: _____

Condition: _____

Date:_____ Hospital: _____

Condition: _____

Date:_____ Hospital: _____

Condition: _____

Date:_____ Hospital: _____

Have you ever had any mental health concerns? Yes No

Have you ever received any of the following services? (Mark all that apply):

___Psychological ___Psychiatric ___Neurological

___Educational ___Counseling/Therapy ___ None

Name/Office of professional: _____ Age seen: _____

Name/Office of professional: _____ Age seen: _____

Name/Office of professional: _____ Age seen: _____

Name/Office of professional: _____ Age seen: _____

Name/Office of professional: _____ Age seen: _____

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

Relation:_____ Diagnoses:_____

Relation:_____ Diagnoses:_____

Relation:_____ Diagnoses:_____

Relation:_____ Diagnoses:_____

Relation:_____ Diagnoses:_____

List **present** medications, supplements, or vitamins you currently take:

1._____
Dosage:_____ Frequency:_____
2._____
Dosage:_____ Frequency:_____
3._____
Dosage:_____ Frequency:_____
4._____
Dosage:_____ Frequency:_____
5._____
Dosage:_____ Frequency:_____
6._____
Dosage:_____ Frequency:_____
7._____
Dosage:_____ Frequency:_____
8._____
Dosage:_____ Frequency:_____

List **past** medications, supplements, or vitamins you have previously taken:

1._____
Dosage:_____ Frequency:_____
2._____
Dosage:_____ Frequency:_____
3._____
Dosage:_____ Frequency:_____
4._____
Dosage:_____ Frequency:_____
5._____
Dosage:_____ Frequency:_____
6._____
Dosage:_____ Frequency:_____
7._____
Dosage:_____ Frequency:_____
8._____
Dosage:_____ Frequency:_____

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, describe:_____

_____

Have you ever had any <u>head injuries</u> when you lost consciousness? Yes No

If yes, describe incident(s) and length of time unconscious: _____

_____

Any episodes of blacking out, fainting or loss of consciousness? Yes No

If yes, describe incident & duration unconscious:_____

_____

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, describe:_____

_____

Do you have urinary incontinence? Yes No

If yes, describe:_____

_____

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

If yes, describe:_____

_____

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

If yes, describe:_____

_____

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

If yes, describe:_____

_____

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

If yes, indicate: Weight Loss Weight Gain

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

If yes, indicate: Increased Decreased

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

If yes, indicate: Mild Moderate Severe

Do you smoke cigarettes **currently**? Yes No

If yes, indicate: Daily Weekly Monthly

Have you **regularly** smoked cigarettes in the **past**? Yes No

If yes, indicate: Daily Weekly Monthly

Do you drink alcohol **currently**? Yes No

If yes, indicate: Daily Weekly Monthly

Have you **regularly** drank alcohol in the **past**? Yes No

If yes, indicate: Daily Weekly Monthly

Do you use recreational drugs **currently**? Yes No

If yes, indicate: Daily Weekly Monthly

Have you **regularly** consumed recreational drugs in the **past**? Yes No

If yes, indicate: Daily Weekly Monthly

Have you overused **prescription medication** to relieve pain/distress? Yes No

If yes, indicate: Daily Weekly Monthly

If you have used recreational drugs or overused prescription medication in the past, or do so currently, indicate type, duration and frequency: _____

_____

_____

Describe your sleep pattern:_____

_____

_____

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

_____

_____

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That's 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