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History Questionnaire

Please complete and bring with you on the day of your appointment.

Demographic Information Please use the back of the page to provide additional information if needed.

Name:_____DOB:_____ Age: _____

Mailing Address: _____

City, State, Zip Code_____

Home Phone Number: _____

Cell Phone/Pager Number: _____

Email address(s): _____

SS#:_____

Gender (circle one): Male Female Marital Status (circle one): Married Single Divorced Widowed Life Partner

Number of years_____

Emergency Contact/Relation: _____ Phone Number(s): _____

Who lives in your home: _____ Children (ages): _____

Source(s) of income: _____ Are you receiving disability? _____

If not, have you ever applied for disability? _____ Approximate date of application: _____

Granted _____ Denied _____ What disability was the application based on? _____

Dates disability was received: _____

Have you ever been arrested?_____ Do you have any legal problems? _____

_____

Do you have any lawsuits pending or do you intend to sue?

_____

Did you learn English as your first language? _____What is the primary language is spoken in your home?

_____

Current Problems/Complaints

Please describe any difficulties you are having with your thinking, concentration, or memory:

Do you have difficulty:

Following what another person is saying during a conversation? _____ Attending to two things at a time? _____ Planning an event like a vacation? _____ Reading maps? _____ Assembling things such as furniture or toys? _____ Remembering names? _____

Remembering conversation or events from a few days ago? _____With your balance or falling? _____

Do you:

Have to write notes to help you remember things? _____

Notice words are on the "tip of your tongue" but you can't think of it? _____ Have to reread material? _____

Get lost easily? _____Have problems dropping things? _____

Have problems picking things up? _____ Have hand tremors? _____

Are you easily distracted? _____ Have you ever left the stove on by accident? _____

Have you ever been told that you have memory problems? _____Can you follow directions, such as recipe? _____

Have you noticed a change in your handwriting? _____

Other issues? _____

Have you had changes in your:

Vision _____

Hearing _____

Taste _____

Smell _____

Touch sense _____

Are any of the difficulties that you have described interfering with your ability to carry out daily activities at home, work, school, or socially (please describe)?

Do you have difficulty sleeping? _____ If so, do you have difficulty falling asleep or staying asleep?_____ Have you noticed a recent weight change?_____ Have you noticed a recent appetite change?_____ What is your general mood?_____ Have you recently experienced depression?_____ Have recently experienced difficulty with anxiety or panic attacks?_____

Have you lost interest in your hobbies?_____ Have you recently experienced problems with temper/ impulse control?_____

Employment:

Current Employment: _____ How long at this job? _____

How many hours do you work per week? _____What are your job duties? _____

Previous Employers and type of work performed: _____

Any employment related problems: _____ If unemployed, what is the last date worked? _____

Have you ever been fired from a job?_____ What kind of work did your parents do for a living?_____

_____ What kind of work does your spouse do for a living? _____

Education:

Indicate the highest Grade completed: _____ Degrees earned: _____

Did you receive any special education or resources classes in school? _____

Were you ever "held back" or "pushed forward" in school: _____ What was your best subject in school: _____

What was your worst subject in school: _____ High school GPA: _____

College GPA: _____ Did you have difficulty learning to read?_____ Did you have difficulty with math?_____ Were you ever told by teachers that you were hyperactive?_____

Did you have trouble making friends when you were younger?

_____

What was the highest level of education completed by your: Mother: _____ Father: _____

Brother: _____ Sister: _____

Medical History

Diabetes	_____	Stroke	_____
Seizures	_____	Kidney Disease	_____
Headaches	_____	Brain Tumor	_____
High Blood Pressure	_____	Multiple Sclerosis	_____
Toxic Exposure	_____	Lupus	_____
Meningitis/Encephalitis	_____	Metabolic Disorders	_____
Cardiovascular Disease	_____	Thyroid Problems	_____
Arteriosclerosis	_____	HIV/AIDS	_____
High Cholesterol	_____	Liver Disease	_____
Obesity	_____	Pulmonary (lung) Disease	_____
Cancer	_____	Malnutrition	_____
TIAs	_____		

Have you ever had periods of:

Blindness?___ _____

Slurred speech? _____

Paralysis? _____

Blurred Vision? _____

Head Injury:

Have you ever had a head injury(s):_____Date(s):_____

After the injury did you experience any of the following symptoms?

Loss of consciousness?_____ For approximately how long? _____

Double or blurry vision?_____Dizziness?_____

Vomiting?_____ Changes in sense of smell?

_____

smell?_____ Changes in sense taste? _____

Were you admitted to the hospital?_____For how long? _____

Name and location of hospital: _____

Did you have a head scan (MRI or CT)? _____ Did you have an EEG? _____

Please list any medications you were started on:

_____

Do you have any other medical problems? _____

What medications do you currently take? Please list:

_____

_____

_____

Have you ever had:

Psychological testing? _____ When: _____ Neuropsychological testing? _____

When: _____ Cognitive testing? _____ When: _____

Doctor: _____Facility or location: _____

Have you ever had:

Physical therapy: _____ date(s) _____

Occupational therapy: _____ date(s) _____

Speech therapy: _____ date(s) _____

Facility and location where services were received: _____

Surgical History

Have you had any previous surgeries (please list)? _____

_____

Developmental History

Were there any complications during your mother's pregnancy with you or during delivery (please describe)?

Were you born on time?

_____

Early – number of weeks _____

Late – number of weeks _____ Weight at birth? _____

Did your mother use drugs or alcohol while she was pregnant with you?

_____

Were you delayed in any of the following areas:

Learning to walk_____

Learning to talk _____

Toilet training _____

Running _____

Throwing/catching _____

Learning to ride a bicycle _____

Substance Abuse/Use

Have you ever used drugs of abuse? _____If so, what, when and how often? _____

Have you, or do you currently drink alcohol? _____ How often? _____Drinks per _____day/week/month

Are you a smoker?_____ packs per _____day/week Number of years: _____

Psychiatric History

Have you ever been diagnosed with a psychiatric disorder? _____

Have you ever been hospitalized for emotional/psychiatric difficulties? _____

Name and location of hospital: _____ Date(s) of hospitalization:

_____

Have you ever received outpatient treatment for emotional or psychiatric problems? _____

Do you have a history of physical, sexual or emotional abuse? _____

Have you ever taken medication for psychiatric problems? _____

If yes, what medications (please list): _____

_____

Have you ever had auditory or visual hallucinations? _____

Have you ever thought about or attempted suicide? _____

FAMILY HISTORY

Please indicate whether any members of your family had any of the following (including children, brothers, sisters, parents, grandparents, aunts, uncles, cousins). Please specify which relative:

Alzheimer's Disease _____

Anxiety, Panic Attacks

_____

Bipolar Disorder (Manic Depression) _____

Dementia _____

Depression_____

Diabetes _____

Heart Disease _____

High Blood Pressure _____

Learning Disabilities _____

Legal Problems _____

Memory Problems _____

Mental Retardation _____

Parkinson's Disease _____

Psychiatric Hospitalizations_____

Schizophrenia_____

Seizure Disorder (Epilepsy)_____

Strokes_____

Substance Abuse_____

Suicide_____

TIAs_____

Other Medical Disorder (please specify) _____

Is there anything else that you would like to add?

_____