

Rachel Lacy, Psy.D., P.C.1805 Herrington Road, Building 3, Ste. B
Lawrenceville, GA 30043

ADULT QUESTIONNAIRE FOR NEUROPSYCHOLOGICAL EVALUATIONS

Confidential

Information requested on this questionnaire will aid us in understanding your problems. We would appreciate you filling it out carefully and fully. Please feel free to add as much information as you want. If you wish, someone who knows you well may help you in filling out the form. You may use the backs of pages if necessary.

Name _____ Date _____

Address _____
(street) (city/state) (zip)

Social Security # _____ Date of birth _____

Home phone # _____ Business phone # _____

Age _____ Sex _____ Marital Status _____

Occupation _____ Current Employer _____

Referred by _____ Phone # _____

In case of emergency, contact: _____

Relationship _____ Phone # _____

Address _____
(street) (city/state) (zip)

Current living situation _____

Driving? _____ Last time drove? _____

Describe the illness(es) or accident(s) that made, or may have made, a big change in your life and give the dates of their occurrence.

Accident/ Illness	Date
_____	_____
_____	_____

Were you unconscious? _____ How long? _____

Is there a period of time for which you have no memory? How long? _____

Describe your physical health. _____

Date of last physical exam _____

Physician(s):

Name	Type of Doctor	Address	Phone

List any prescribed medications you are presently taking. Include dosages and dates started.

Medication	Dosage	Times Taken Per Day	Date Started

List over-the-counter medications you take fairly often, including vitamins, supplements and herbal remedies.

Describe any other serious illness, hospitalizations, accidents or operations:

Date	Name of doctor or hospital	Location	Nature of Illness/ Surgery

Please indicate if you have had any history of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Head trauma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anoxia or hypoxia | <input type="checkbox"/> HIV | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Syncope |
| <input type="checkbox"/> Cancer treatment | <input type="checkbox"/> Hyponatremia | <input type="checkbox"/> Systemic lupus erythematosus |
| <input type="checkbox"/> Cerebral vascular disease | <input type="checkbox"/> Hypoxemia | <input type="checkbox"/> Toxic or heavy metal exposure |
| <input type="checkbox"/> Coronary dysfunction | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Vascular disease |
| <input type="checkbox"/> Cortisol deficiency | <input type="checkbox"/> Motor Difficulties | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pernicious Anemia | <input type="checkbox"/> Vitamin deficiencies |
| <input type="checkbox"/> Gastrointestinal disorders | <input type="checkbox"/> Porphyria | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Genital or urinary problems | <input type="checkbox"/> Renal dialysis | _____ |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory problems | _____ |

Developmental History:

Problems or maternal use of drugs during pregnancy _____

Place of birth _____ Birth order _____

Birth weight _____ Problems during or after delivery _____

Developmental milestones: age walking _____ age talking _____ age toileting _____

Engaging peers _____ Tolerating separation _____ playing cooperatively _____

Childhood diseases or history of health problems: _____

Emotional or behavioral problems during childhood and adolescence: _____

History of learning disabilities _____

History of ADD/ ADHD: _____

History of physical, sexual, or emotional abuse/trauma _____

History of head trauma _____

Please indicate if the following stressors are currently present in your life. Circle all that apply and describe the nature of the problem.

Financial difficulties _____

Recent problems with the law _____

Sexual Difficulties _____

Pending Litigation _____

Loss of Friends _____

Recent family conflict _____

Conflicts with others _____

Academic difficulties _____

Work related difficulties _____

Other _____

History of previous emotional or psychiatric difficulties: _____

History of suicidal ideation or behavior: _____

History of psychiatric treatment: _____

History of hospitalizations for emotional problems: _____

History of psychiatric medications:

Name of Medication	Date Started	Length of Time Taken	Effectiveness

Past alcohol and drug use:

Name of Substance	Age started	How Much?	How Often?	Heaviest Use?

Present alcohol and drug use:

Name of Substance	Age started	How Much?	How Often?	Heaviest Use?
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Do you use tobacco products? _____ What type? _____ How much per day? _____

Past use of tobacco: Age started _____ Heaviest use? _____

For how long? _____ If stopped, when? _____

Do you use caffeine? _____ Coffee, tea, soda, or pills? _____ How much per day? _____

List all the people living in your current household. Note any adopted or step-children.

Name	Relationship	Age	Education	Occupation
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List the people in your family of origin. Include parents and siblings. If deceased, note year of death and age at the time.

Name	Relationship	Age	Education	Occupation
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List other members of your immediate family not previously listed. Include any previous marriages, and note any deaths.

Name	Relationship	Age	Location	Education	Occupation
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Marital status _____ Number of years married _____

History of previous marriages _____

Previous and current marital difficulties _____

Physical and emotional health of children _____

Living status of children _____

Effects of children on patient _____

Current support system _____

Circle the physical or neurological problems that run in your family.

Arthritis	Diabetes	Huntington's chorea	Stroke	Cancer
Epilepsy	Heart Disease	Bipolar Disorder	Depression	Schizophrenia
Alzheimer Disease		Highblood pressure	Thyroid Disorders	
Other _____				

Family alcohol and substance abuse history:

Family psychiatric history, illnesses and/or treatment:

Family criminal history:

Patient's legal history: (If applicable) Arrests _____

Type of criminal offense _____

Time served in jail _____ Time in probation _____

Prior history of litiagation _____

Prior history of disability claims _____

Current legal problems _____

Current court cases _____

Education history (beginning with High School)

School	Dates	Location	Degree/ diploma
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Highest grade completed: _____

Reasons for leaving school or college: _____

Technical school training/ certificates obtained: _____

Describe any school related difficulties such as trouble learning to read, write, spell or do arithmetic; repeating a grade, or being placed in special education classes.

History of conduct or behavioral problems: _____

What were your grades like in elementary school (please provide grades obtained)? Were they fairly consistent? If not, when did you do well and when did you do less well? _____

What were your grades like in high school? Were they fairly consistent? If not, when did you do well and when did you do less well? _____

Extracurricular activities in school: _____

Awards and achievements: _____

What were your grade like in college or technical school? Were they fairly consistent? If not, when did you do well and when did you do less well? _____

Extracurricular activities in college: _____

Awards and achievements: _____

Are you right-handed ? ___ left-handed ? ___ or ambidextrous? _____
(check one and explain if ambidextrous)

List anyone in your family of origin who was left-handed or ambidextrous. _____

Work history BEFORE illness or accident:

Job	Dates	Location	Duties	Reason for leaving

Work history AFTER illness or accident:

Job	Dates	Location	Duties	Reason for leaving

Longest held job: _____ History of job terminations: _____

History of job promotions: _____

Job related goals: _____

Military service: Branch and dates of service: _____

Jobs held within service: _____

Training received while in service: _____

Combat history: _____

Rank at discharge: _____ Type of discharge: _____

Service connected disabilities _____

What were your main hobbies and interests BEFORE the illness or accident? _____

What are your main hobbies and interests AFTER the illness or accident? _____

Cultural Background: Country of Birth: _____ First language spoken: _____

Other languages spoken: _____ Preferred language: _____

Ethnic background of patients and family: _____

History of Discriminations: _____

Religious background: _____ Church/ Temple/ Mosque attendance _____

In the next sections please describe yourself in regard to each of the following aspects of mental functioning behavior. Describe the situation before the accident or illness on the left and the recent or current on condition on the right. *If the condition is one you have experienced all of your life, then only complete the column on the left side of the page.*

Before the accident or illness

Recently and currently

Concentration

Energy and activity level

Depression

Elation and other types of high mood

Sleep Quality

Anger or Anger Control Problems

Agitation or Irritability

Appetite for food

Sexual behavior and sexual interest

Consumption of alcohol and other drugs

Hearing

Vision and other aspects of sight

Ability to find your way around - Spatial ability

Headaches

Before the accident or illness

Recently and currently

Pains other than in the head

Fatigue

Understanding what you hear

Finding words when you know what you want to say

Memory for things people say or things you need to do

Imagery and memory for faces

Reading

Calculating - balancing check book

Playing or listening to music

Motor behavior - skillful activity

Unusual sensations or strange experiences

Ability to relax and experience pleasure

Social behavior - being with people

Ability to work or hold job

Please use the back for additional information which you think would be helpful.

(signature) (date)

If another person assisted in completing this form, please enter appropriate information below.

Name _____ Relationship to client _____

Address _____ Phone _____