ADULT
NEUROPSYCHOLOGICAL HISTORY QUESTIONNAIRE
(ANHQ)

Patient's Name______________________________________________________________________
Address (Street, City, ST, Zip)__________________________________________________________________________________________
Patient phone (H)____________________________ (W)___________________________________
Guardian phone (H)____________________________ (W)___________________________________
Age______ Birth date______________ Sex________ Education______________________________
Ethnic or Racial Background_____________________ Religion_____________________________
Primary Language _____________________________ Secondary Language____________________
Hand used for writing: (check one)  Right hand_____      Left Hand_____
Social Security Number _____ _____ _____
Job Title_______________________________________________________________________________
School attending________________________________________________________________________
Who do you live with?___________________________________________________________________
Medical diagnosis:  (1) ___________________________________________________________________
(2) _______________________________________________________________________________
(3) _______________________________________________________________________________
(4) _______________________________________________________________________________
(5) _______________________________________________________________________________
(6) _______________________________________________________________________________
(7) _______________________________________________________________________________

Who referred you for this evaluation?________________________________________________________
Please rate problems/concerns in order of importance:
(1) _______________________________________________________________________________
(2) _______________________________________________________________________________
(3) _______________________________________________________________________________
(4) _______________________________________________________________________________
(5) _______________________________________________________________________________
(6) _______________________________________________________________________________
(7) _______________________________________________________________________________

THIS FORM HAS BEEN COMPLETED BY:  Patient____ Other____
If not completed by patient, please provide the following information:
Name____________________________________ Relationship to patient________________________
SYMPTOM SURVEY

For each symptom that applies, place a check in the small box. Then, check if this is a NEW symptom (post injury or within the past year) or an OLD symptom (pre injury or over one year). Add any helpful comments next to the item.

1) PROBLEM SOLVING
✓ New Old

☐ ___ ___ Difficulty figuring out how to do new things
☐ _____ _____ Difficulty planning ahead
☐ _____ _____ Difficulty thinking as quickly as needed
☐ _____ _____ Difficulty doing things in the right order (sequence problems)
☐ _____ _____ Difficulty changing a plan or activity when necessary
☐ _____ _____ Difficulty completing an activity in a reasonable amount of time
☐ _____ _____ Difficulty doing more than one thing at a time
☐ _____ _____ Difficulty switching form one activity to another activity
☐ _____ _____ Other:_________________________________________________________________________________

2) SPEECH, LANGUAGE, AND MATH SKILLS
✓ New Old

☐ ___ ___ Difficulty finding the right word to say
☐ _____ _____ Difficulty understanding what others are saying
☐ _____ _____ Unable to speak
☐ _____ _____ Difficulty staying with one idea
☐ _____ _____ Difficulty writing letters or words (not due to a motor problem)
☐ _____ _____ Slurred speech
☐ _____ _____ Odd or unusual speech sounds
☐ _____ _____ Difficulty with math (e.g., checkbook balancing, making change, etc.)
☐ _____ _____ Difficulty understanding what I read
☐ _____ _____ Difficulty spelling
☐ _____ _____ Other:_________________________________________________________________________________

3) NONVERBAL SKILLS
✓ New Old

☐ ___ ___ Difficulty telling right from left
☐ _____ _____ Difficulty doing things I should automatically be able to do (e.g., brushing teeth, etc.)
☐ _____ _____ Problems drawing or copying
4) **CONCENTRATION AND AWARENESS**

<table>
<thead>
<tr>
<th>New</th>
<th>Old</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Difficulty keeping my attention on a task or activity</td>
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<tr>
<td></td>
<td></td>
<td>Highly distractible</td>
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<tr>
<td></td>
<td></td>
<td>Lose my train of thought easily</td>
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<tr>
<td></td>
<td></td>
<td>Problems concentrating for any length of time</td>
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<tr>
<td></td>
<td></td>
<td>Difficulty writing letters or words (not due to a motor problem)</td>
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<tr>
<td></td>
<td></td>
<td>Become easily confused or disoriented</td>
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<tr>
<td></td>
<td></td>
<td>Blackout spells (fainting)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>My mind goes blank</td>
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<tr>
<td></td>
<td></td>
<td>Aura (strange feelings)</td>
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<td></td>
<td></td>
<td>Don’t feel very alert or aware of things</td>
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<tr>
<td></td>
<td></td>
<td>Other: ___________________________________________________________________</td>
</tr>
</tbody>
</table>

5) **MEMORY**

<table>
<thead>
<tr>
<th>New</th>
<th>Old</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Forgetting where I leave things (e.g., keys, gloves, etc.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Forgetting names</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Forgetting what I should be doing</td>
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<tr>
<td></td>
<td></td>
<td>Forgetting where I am or where I am going</td>
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<tr>
<td></td>
<td></td>
<td>Forgetting events that happened quite recently (e.g., my last meal)</td>
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<tr>
<td></td>
<td></td>
<td>Forgetting events that happened long ago (months or years)</td>
</tr>
</tbody>
</table>
**Adult Neuropsychological History Questionnaire**

1. **□ _____ _____** Need someone to give me a hint so I can remember things
2. **□ _____ _____** Relying more and more on notes to remember things
3. **□ _____ _____** Forgetting the order of things (e.g., when cooking, etc.)
4. **□ _____ _____** Forgetting facts, but I can remember how to do things
5. **□ _____ _____** Forgetting faces of people I know (when they are not present)
6. **□ _____ _____** Frequently forgetting appointments
7. **□ _____ _____** Other: ____________________________________________

**6) MOTOR AND COORDINATION**

<table>
<thead>
<tr>
<th></th>
<th>New</th>
<th>Old</th>
<th>Check the side this occurs on</th>
<th>Right</th>
<th>Left</th>
<th>Both Sides</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fine motor control problems (using a pencil, key, etc.)</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Weakness on one side of my body</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Difficulty holding onto things</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Tremor or shakiness</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Muscle tics or strange movements</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>My writing is very small</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Walking more slowly than other people</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<td></td>
<td></td>
<td></td>
<td>Feeling stiff</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<td></td>
<td></td>
<td></td>
<td>Balance problems</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Difficulty starting to move</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Jerky muscles</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Muscles tire quickly</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Often bumping into things</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<td></td>
<td></td>
<td></td>
<td>Other: ____________________________________________</td>
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</tbody>
</table>

**7) SENSORY**

<table>
<thead>
<tr>
<th></th>
<th>New</th>
<th>Old</th>
<th>Check the side this occurs on</th>
<th>Right</th>
<th>Left</th>
<th>Both Sides</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Loss of feeling or numbness</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Tingling or strange skin sensations</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Difficulty telling hot from cold</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Problems seeing on one side</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Blurred vision</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Blank spots in vision</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Brief periods of blindness</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
</tbody>
</table>
## Adult Neuropsychological History Questionnaire

- **See stars or flashes of light**
- **Double vision**
- **Difficulty looking quickly from one object to another object**
- **Need to squint or move closer to see clearly**
- **Losing hearing**
- **Ringing in my ears or hearing strange sounds**
- **Difficulty tasting food**
- **Difficulty smelling**
- **Smelling strange odors**
- **Headaches**
- **Dizziness**
- **Nausea or vomiting**
- **Urinary incontinence**
- **Loss of bowel control**
- **Excessive tiredness**
- **Pain**
- **Sadness or depression**
- **Anxiety or nervousness**
- **Stress**
- **Sleeping problems:**
  - Falling asleep
  - Staying asleep
- **Become angry or irritable more easily**
- **Euphoria (feeling on top of the world)**
- **Much more emotional (e.g., cry more easily)**
Adult Neuropsychological History Questionnaire

_____ Feel as if I just do not care anymore
_____ Feel like hurting myself and/or another person
_____ Less inhibited (do things I would not do before)
_____ Hear voices or see things others do not hear or see
_____ Change in eating habits:
_____ Change in interest in sex:
_____ Other recent change in behavior or personality:

10) Overall, my symptoms have developed: _____ Slowly   _____ Quickly
11) My symptoms occur: _____ Occasionally _____ Often
12) Over the past 6 months my symptoms have: _____ Stayed about the same
                                          _____ Worsened
                                          _____ Gotten better

EARLY HISTORY

13) You were born On time _____ Prematurely _____ Late _____
14) Your weight at birth: _____ lbs. _____ oz.
15) Mother's weight gain during pregnancy: _____ lbs.
16) Were there any problems associated with your birth (e.g., oxygen deprivation, unusual birth position, etc.) or
the period immediately afterward (e.g., need for oxygen, special equipment used, convulsions, illness, etc.)
   _____ Yes   _____ No
   If yes, describe:__________________________________________________________________________________________

17) Check all that applied to your mother while she was pregnant with you:
   _____ Accident
   _____ Alcohol use
   _____ Cigarette smoking
   _____ Drug use (marijuana, speed, cocaine, LSD, etc.)
   _____ Poor nutrition
   _____ Psychological problems
   _____ Other problems: __________________________________________________________________________________________

18) List all the medications (prescribed or over-the-counter) your mother took while pregnant.
   __________________________________________________________________________________________________________

19) During her pregnancy, did your mother live near a polluted area (e.g., toxic waste dump) or other hazardous
area (nuclear plant, industrial area, pesticide sprayed area, etc.)? _____ Yes   _____ No
   If yes, describe:__________________________________________________________________________________________
20) Rate your developmental progress as it has been reported to you by checking one description for each area:

<table>
<thead>
<tr>
<th>Area</th>
<th>Early</th>
<th>Average</th>
<th>Late</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall development</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21) As a child, did you have any of these conditions? (Check all that apply.)

- _____ Attention problems
- _____ Head injury
- _____ Muscle tightness or weakness
- _____ Clumsiness
- _____ Hearing problems
- _____ Speech problems
- _____ Developmental delay
- _____ Hyperactivity
- _____ Vision problems
- _____ Frequent ear infections
- _____ Learning disability
- _____ Psychological / behavior problems
- _____ Problems socializing
- _____ Drug use
- _____ Involvement with police or juvenile Authorities

Other problems: ________________________________________________________________

MEDICAL HISTORY

CHILDHOOD MEDICAL HISTORY

22) Check all the conditions that were diagnosed when you were a child. Add any helpful details (age at diagnosis, treatment provided, etc.)

- _____ Allergies
- _____ Asthma
- _____ Brain infection or disease
- _____ Cancer
- _____ Cerebral palsy
- _____ Chicken pox
- _____ Colds (excessive)
- _____ Diabetes
- _____ Encephalitis
- _____ Other diseases or disabilities: ______________________________________________________________

- _____ Epilepsy or seizures
- _____ Fevers (104 F or higher)
- _____ Heart problems
- _____ Immune system disease
- _____ Kidney problems
- _____ Lung (respiratory) disease
- _____ Measles
- _____ Meningitis
- _____ Oxygen deprivation
- _____ Pneumonia
- _____ Poisoning
- _____ Polio
- _____ Rheumatic fever
- _____ Scarlet fever
- _____ Tuberculosis
- _____ Venereal disease
- _____ Whooping cough
- _____ Psychological

23) As a child, were you exposed to excessive amounts of lead (e.g., eating paint chips, living next to high Concentration of automobile exhaust fumes, etc.)? _____ Yes _____ No

If yes, explain: ________________________________________________________________

24) As a child, did you have an accident which required a hospital visit? _____ Yes _____ No

If yes, describe what happened: ______________________________________________________________
25) Did you ever suffer a serious injury to your head?  _____ Yes  _____ No
   If yes, explain the circumstances and any problems you had afterward: __________________________________________
   _______________________________________________________________________________________________
31) Do you have epilepsy or a seizure disorder? _____ Yes _____ No
If yes, check the one you have been diagnosed with:

PARTIAL
_____ Simple partial (Jacksonian)
_____ Complex partial (Psychomotor)
_____ Partial evolving into generalized

GENERALIZED
_____ Absence (Petit mal)
_____ Myoclonic
_____ Clonic
_____ Tonic
_____ Tonic–clonic (Grand mal)

_____ I HAVE A SEIZURE DISORDER BUT DO NOT KNOW WHICH TYPE.
Please describe it:______________________________________________________________

32) Describe all of the hospitalizations you have had:
   a) _______________________________________________________________________________________
   b) _______________________________________________________________________________________
   c) _______________________________________________________________________________________
   d) _______________________________________________________________________________________

FAMILY HISTORY
The following questions deal with your biological mother, father, brothers, and sisters.

MOTHER
33) What is your mother’s name? Include maiden name):______________________________________________
34) Is she alive?  Yes_____ No_____ If deceased, what was the cause of death?________________________
35) Mother’s occupation: _______________________________________________________________________
36) Mother’s level of education: __________________________________________________________________
37) Mother’s hobbies: __________________________________________________________________________
38) Does your mother have a known or suspected learning disability?  Yes_____ No_____  
If yes, describe: ___________________________________________________________________________
39) Does your mother have a known or suspected psychological disorder?  Yes_____ No_____  
If yes, describe: ___________________________________________________________________________
40) Briefly describe your mother’s health history:__________________________________________________

FATHER
41) What is your father’s name?____________________________________________________________________
42) Is he alive?  Yes_____ No_____  If deceased, what was the cause of death?________________________
43) Father’s occupation: _______________________________________________________________________
44) Father’s level of education: __________________________________________________________________
45) Father’s hobbies: __________________________________________________________________________
46) Does your father have a known or suspected learning disability? Yes____ No____
   If yes, describe:________________________________________________________________________________________

47) Does your father have a known or suspected psychological disorder? Yes_____ No_____  
   If yes, describe:________________________________________________________________________________________

48) Briefly describe your father’s health history:________________________________________________________________________________________

49) When you were born what was your mother’s age? _____ Father’s age_____

50) How many brothers and sisters do you have? _____
   Names and ages:________________________________________________________________________________________________________

51) Where are you in the birth order? ______

52) Are there any problems (physical, academic or psychological) associated with any of your brothers or sisters? Yes_____ No_____  
   If yes, describe:________________________________________________________________________________________

53) Who raised you?
   _____ Biological parent(s)  _____ Relatives  _____ Foster parents
   _____ Biological parent plus other person  _____ Adoptive parents
   _____ Institutional setting  _____ Other
   Who? ___________________________________________________________________________________________________

54) What languages were spoken at home when you were a child?
   1) _________________________________________  2) ____________________________________________________
   Primary language  Secondary language

55) Please check all that exist(ed) in close biological (blood) family members (parents, brothers, sisters, grandparents, aunts, uncles). Note who it was and describe the problem where indicated.

   Who?
   _____ Epilepsy or seizures
   _____ Learning disability
   _____ Left-handedness
   _____ Mental retardation

   Neurological (brain) disease
   _____ Alzheimer’s disease or senility
   _____ Huntington disease
   _____ Multiple sclerosis
   _____ Parkinson disease
   _____ Other neurological disease (describe)
Psychiatric illness

_____ Alcoholism
_____ Bipolar illness (manic–depression)
_____ Depression
_____ Personality disorder
_____ Schizophrenia
_____ Other psychiatric illness (describe)

_____ Speech or language disorder
_____ Other major disease or disorder (describe)

PERSONAL HISTORY

MARITAL HISTORY

56) Current marital status: Married_____ Divorced_____ Widowed_____ Separated_____
57) Years married to current spouse: _____
58) Number of times married: _____
59) Spouse’s name: ___________________________ Spouse’s age: ______
60) Spouse’s occupation: ___________________________________________________________________
61) Spouse’s education: _____________________________________________________________________
62) Spouse’s health: Excellent_____ Good_____ Poor_____
   If problems, please describe: ________________________________________________________________
   _______________________________________________________________________________________

63) Not married, but living with someone: Yes_____ No_____ His/her age: ______
   His/her health: Excellent_____ Good_____ Poor_____
   If problems, please describe: ________________________________________________________________
   _______________________________________________________________________________________
   His/her occupation: _______________________________________________________________________
   Partner’s education: ______________________________________________________________________

64) Do you have any children: Yes_____ No_____ His/her ages: _____________________________
65) Do your children have learning disabilities or other systemic diseases? Yes_____ No_____
   If yes, please explain: _________________________________________________________________
   ______________________________________________________________________________________

EDUCATIONAL HISTORY

66) Highest grade or degree earned: ___________________________________________________________
67) How would you describe your usual performance as a student in (please circle highest level):

<table>
<thead>
<tr>
<th>Name of School</th>
<th>City/State</th>
<th># Yrs Completed</th>
<th>Date Finished</th>
<th>Average Grade</th>
<th>Diploma</th>
</tr>
</thead>
<tbody>
<tr>
<td>High school</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>College</td>
<td></td>
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</tbody>
</table>

Grades 1-6 __________________________________________________________
Grades 7-8/9 _________________________________________________________
Grades 9/10-12 _____________________________________________________
University _________________________________________________________
Post-graduate _____________________________________________________
Other _____________________________________________________________

Please provide any additional helpful comments about your academic performance: __________________________________________________________

68) What was your best subject(s)? __________________________ Weakest subject(s) __________________________

69) Were you ever held back to repeat a grade? Yes_____ No_____ 

If yes, what grade(s): ____________________________________________ Reason: ____________________________________________

70) Were you ever in any special class(es) or received special services? Yes_____ No_____ 

If yes, what grade? Or age? What type of class? ______________________

OCCUPATIONAL HISTORY

71) Current job title: _____________________________________________

72) Salary: Under $10,000_____ $10,000-$29,999_____ $30,000-$50,000_____ $50,000-$70,000_____ 
Over $70,000_____

73) How long have you been on this job? ____________________________

74) Current job responsibilities: ________________________________

(Start with most recent) Reason for leaving Time on this job

75) Prior jobs: 

a) ____________________________ ____________________________

b) ____________________________ ____________________________

c) ____________________________ ____________________________

d) ____________________________ ____________________________

76) At any time on a job, were you exposed to toxic, hazardous, noxious or otherwise dangerous or unusual substances (e.g., lead, mercury, radiation, solvents, pesticides, chemicals, etc)? Yes_____ No_____
MILITARY HISTORY

77) Branch: ____________________________________________________________

78) Discharge rank: __________________________ Type of discharge:____________________________

79) Major military duties:__________________________________________________________

80) Did you sustain any physical injuries in the military?    Yes_____    No_____

If yes, describe:________________________________________________________________________

81) Were you ever exposed to any dangerous or unusual substances during your service (e.g., Agent Orange, radiation, etc)?    Yes_____    No_____

If yes, explain:___________________________________________________________________________

RECREATION/SOCIALIZATION

82) Briefly list the types of recreation activities (sports, games, TV, hobbies, etc.) you engaged in prior to your Injury or illness? _________________________________________________________________________

_______________________________________________________________________________________

83) Briefly list the types of recreation activities that you presently engage in: _____________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

84) Briefly list typical social activities you engaged in (Church, clubs, service organizations, etc.) before your Injury or illness: __________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

85) Briefly list typical social activities you engage in:________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

SUBSTANCE USE HISTORY

ALCOHOL

86) I started drinking regularly at age:

Less than 10 years old _____ 10-15______ 16-18_____ 19-21_____ over 21_____  

87) I drink alcohol:    rarely or never_____ 1-2 days/week_____ 3-5 days/week_____ Daily_____  

I used to drink but have stopped_____ Date stopped_____________

88) Preferred type(s) of drinks:________________________________________________________________________

89) Usual number of drinks I have at a time:________________________________________________________________

90) My last drink was:    Less than 24 hours ago_____ 24-48 hours ago_____ over 48 hours ago_____
91) Check all that apply:
   _____ I can drink more than most people my age and size before I get drunk.
   _____ I sometimes get into trouble (fights, legal difficulty, problems at work, conflicts with family, accidents, etc.)
   after drinking
   _____ I sometimes black out after drinking

**DRUGS**

92) Please check all the drugs you are now using or have used in the past:

<table>
<thead>
<tr>
<th>Presently using</th>
<th>Used in the past</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ Amphetamines (inc. diet pills)</td>
<td>_____</td>
</tr>
<tr>
<td>_____ Barbiturates (downers, etc.)</td>
<td>_____</td>
</tr>
<tr>
<td>_____ Cocaine or crack</td>
<td>_____</td>
</tr>
<tr>
<td>_____ Hallucinogenics (LSD, acid, STP, etc.)</td>
<td>_____</td>
</tr>
<tr>
<td>_____ Inhalants (glue, nitrous oxide, ect.)</td>
<td>_____</td>
</tr>
<tr>
<td>_____ Marijuana</td>
<td>_____</td>
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<tr>
<td>_____ Opiate narcotics (heroin, morphine, etc.)</td>
<td>_____</td>
</tr>
<tr>
<td>_____ PCP (or angel dust)</td>
<td>_____</td>
</tr>
</tbody>
</table>

Please list all other drugs: __________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

(93) Do you consider yourself dependent on any above drug?  
Yes____  No____
Which one(s)? ____________________________________________________________________
______________________________________________________________________________

(94) Do you consider yourself dependent on any prescription drug?  
Yes____  No____
Which one(s)? ____________________________________________________________________
______________________________________________________________________________

95) Check all that apply:
   _____ I have gone through drug withdrawal
   _____ I have used I.V. drugs
   _____ I have been in drug treatment

96) Have you ever been arrested for, or convicted of, any offense?  
Yes____  No____
If so, please explain: ______________________________________________________________________
________________________________________________________________________________________

**MEDICAL**

97) Identify the physician who is most familiar with your recent problems:
   Name of physician: ________________________________________________________________
   Address: __________________________________________________________________________
____________________________________________________________________________________
Phone: _______________________________________________________________________________
Date of your last medical check-up:__________________________________________________________

Findings of the check-up:________________________________________________________________

______________________________________________________________________________________

98) Have you had a prior psychiatric, psychological or neuropsychological evaluation?   Yes____   No____
   If yes, complete this information:
   Name of Doctor:__________________________________________________________________________
   Address:_________________________________________________________________________________
   Phone:__________________________________________________________________________________
   Date of and reason for this evaluation________________________________________________________________
   Findings of the evaluation:____________________________________________________________________

99) Is there any other information that you believe would be relevant to this evaluation? ______________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

100) What do you believe is your biggest problem? _______________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

101) Are you presently involved in a lawsuit?   Yes____   No____
   If so, what?______________________________________________________________________________
   Attorney’s Name:_________________________________________________________________________
   Address:_________________________________________________________________________________
   Phone number:____________________________________________________________________________
   How many lawsuits have you filed in your life?______________________________________________

102) Do you presently operate a vehicle?   Yes____   No____
   Do you have a current license?   Yes____   No____   State:________________________
   License Number:______________   Type___________   Restrictions?___________________________
MEDICAL HISTORY

Patient’s Name: ____________________________ Date __________________________

Have you suffered from any serious childhood illness: Yes______ No______
If yes, which ones? ____________________________

Do you currently have or have had a history of any of the following conditions? (Circle all that apply)

- Allergies
- Arthritis
- Asthma
- Broken Bones
- Bronchitis
- Cardiovascular Disease
- Cancer
- Chronic Pain
- Colitis
- Concussion
- Congenital Abnormality
- Diabetes
- Emphysema
- Gall Stones
- Head Trauma
- Heart Attack
- Hemorrhoids
- Herpes
- High Blood Pressure
- Irritable Bowel Syndrome
- Kidney Disease
- Liver Disease
- Lupus
- Mental Illness
- Pulmonary Disease
- Seizures
- Stroke
- Thyroid Disease
- Tuberculosis
- Ulcers
- Other___________________________
- Other___________________________
- Other___________________________

Is there any family (blood relative) history of serious disease? Yes______ No______
If so, which ones?__________________________________________________________
Have you had any operations/surgical procedures?  

Yes____  No_____  

If so, please list procedure(s) and year(s):__________________________________________

Do you currently have or have you had a history of any of the following symptoms?  (Circle all that apply)

- Headaches
- Blackouts
- Poor Vision
- Congested Nose
- Sore Throat
- Irregular Heartbeat
- Nausea
- Bloated Stomach
- Urination Problems
- Twitching
- Numbness
- Sleep Problems
- Weight Loss
- Sexual Performance Problems
- Other:________________________________________

Do you have any pains?  

Yes____  No_____  

If so, what body part?___________________________________________________

List any prescription medications you take:________________________________________

________________________________________

Do you use drugs?  

Yes____  No_____  

If so, which ones:________________________________________

Do you drink alcohol?  

Yes____  No_____  

If so, how many times per month?___________

On an average, how many drinks do you consume when you have alcohol?____________

Do you smoke tobacco?  

Yes_____  No_____  

If so, how much per day?____________

Have you ever had any mental health treatment?  

Yes_____  No_____  

If yes, when treated and for what condition?________________________________________

________________________________________
Is there any family (blood relative) history of mental illness?  Yes____  No____
If so, which condition(s)?____________________________________________________