

## 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) \_\_\_\_\_

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**

- |                          |            |            |  |
|--------------------------|------------|------------|--|
| ✓                        | <b>New</b> | <b>Old</b> |  |
| <input type="checkbox"/> | ---        | ---        | Difficulty figuring out how to do new things                     |
| <input type="checkbox"/> | ----       | ----       | Difficulty planning ahead  |
| <input type="checkbox"/> | -----      | -----      | Difficulty thinking as quickly as needed                         |
| <input type="checkbox"/> | -----      | -----      | Difficulty doing things in the right order (sequence problems)   |
| <input type="checkbox"/> | -----      | -----      | Difficulty changing a plan or activity when necessary            |
| <input type="checkbox"/> | -----      | -----      | Difficulty completing an activity in a reasonable amount of time |
| <input type="checkbox"/> | -----      | -----      | Difficulty doing more than one thing at a time                   |
| <input type="checkbox"/> | -----      | -----      | Difficulty switching form one activity to another activity       |
| <input type="checkbox"/> | -----      | -----      | Other:.....  |

**2) SPEECH, LANGUAGE, AND MATH SKILLS**

- |                          |            |            |   |
|--------------------------|------------|------------|---|
| ✓                        | <b>New</b> | <b>Old</b> |   |
| <input type="checkbox"/> | ---        | ---        | Difficulty finding the right word to say                              |
| <input type="checkbox"/> | ----       | ----       | Difficulty understanding what others are saying                       |
| <input type="checkbox"/> | -----      | -----      | Unable to speak   |
| <input type="checkbox"/> | -----      | -----      | Difficulty staying with one idea                                      |
| <input type="checkbox"/> | -----      | -----      | Difficulty writing letters or words (not due to a motor problem)      |
| <input type="checkbox"/> | -----      | -----      | Slurred speech  |
| <input type="checkbox"/> | -----      | -----      | Odd or unusual speech sounds  |
| <input type="checkbox"/> | -----      | -----      | Difficulty with math (e.g., checkbook balancing, making change, etc.) |
| <input type="checkbox"/> | -----      | -----      | Difficulty understanding what I read                                  |
| <input type="checkbox"/> | -----      | -----      | Difficulty spelling   |
| <input type="checkbox"/> | -----      | -----      | Other:.....   |

**3) NONVERBAL SKILLS**

- |                          |            |            |   |
|--------------------------|------------|------------|---|
| ✓                        | <b>New</b> | <b>Old</b> |   |
| <input type="checkbox"/> | ---        | ---        | Difficulty telling right from left  |
| <input type="checkbox"/> | ----       | ----       | Difficulty doing things I should automatically be able to do (e.g., brushing teeth, etc.) |
| <input type="checkbox"/> | -----      | -----      | Problems drawing or copying   |

- -----    Difficulty dressing (not due to physical difficulty)
- -----    Difficulty writing letters or words (not due to a motor problem)
- -----    Problems finding my way around places I have been to before
- -----    Difficulty recognizing objects or people
- -----    Parts of my body do not seem as if they belong to me
- -----    Difficulty writing letters or words (not due to a motor problem)
- -----    Unaware of things on one side of my body:    Right side -----    Left side -----
- -----    Decline in my musical abilities
- -----    Not aware of time (i.e., time of day, season, year)
- -----    Slow reaction time
- -----    Other:-----

4) **CONCENTRATION AND AWARENESS**

- ✓    **New    Old**
- -----    Difficulty keeping my attention on a task or activity
  - -----    Highly distractible
  - -----    Lose my train of thought easily
  - -----    Problems concentrating for any length of time
  - -----    Difficulty writing letters or words (not due to a motor problem)
  - -----    Become easily confused or disoriented
  - -----    Blackout spells (fainting)
  - -----    My mind goes blank
  - -----    Aura (strange feelings)
  - -----    Don't feel very alert or aware of things
  - -----    Other:-----

5) **MEMORY**

- ✓    **New    Old**
- -----    Forgetting where I leave things (e.g., keys, gloves, etc.)
  - -----    Forgetting names
  - -----    Forgetting what I should be doing
  - -----    Forgetting where I am or where I am going
  - -----    Forgetting events that happened quite recently (e.g., my last meal)
  - -----    Forgetting events that happened long ago (months or years)

- Need someone to give me a hint so I can remember things
- Relying more and more on notes to remember things
- Forgetting the order of things (e.g., when cooking, etc.)
- Forgetting facts, but I can remember how to do things
- Forgetting faces of people I know (when they are not present)
- Frequently forgetting appointments
- Other:-----

6) **MOTOR AND COORDINATION**

Check the side this occurs on  
**Right      Left      Both Sides**

✓	New	Old		Right	Left	Both Sides
<input type="checkbox"/>	-----	-----	Fine motor control problems (using a pencil, key, etc.	-----	-----	-----
<input type="checkbox"/>	-----	-----	Weakness on one side of my body	-----	-----	-----
<input type="checkbox"/>	-----	-----	Difficulty holding onto things	-----	-----	-----
<input type="checkbox"/>	-----	-----	Tremor or shakiness	-----	-----	-----
<input type="checkbox"/>	-----	-----	Muscle tics or strange movements	-----	-----	-----
<input type="checkbox"/>	-----	-----	My writing is very small			
<input type="checkbox"/>	-----	-----	Walking more slowly than other people			
<input type="checkbox"/>	-----	-----	Feeling stiff			
<input type="checkbox"/>	-----	-----	Balance problems			
<input type="checkbox"/>	-----	-----	Difficulty starting to move			
<input type="checkbox"/>	-----	-----	Jerky muscles			
<input type="checkbox"/>	-----	-----	Muscles tire quickly			
<input type="checkbox"/>	-----	-----	Often bumping into things			
<input type="checkbox"/>	-----	-----	Other:-----			

7) **SENSORY**

Check the side this

occurs on	New	Old		Right	Left	Both Sides
✓	-----	-----	Loss of feeling or numbness	-----	-----	-----
<input type="checkbox"/>	-----	-----	Tingling or strange skin sensations	-----	-----	-----
<input type="checkbox"/>	-----	-----	Difficulty telling hot from cold	-----	-----	-----
<input type="checkbox"/>	-----	-----	Problems seeing on one side	-----	-----	-----
<input type="checkbox"/>	-----	-----	Blurred vision	-----	-----	-----
<input type="checkbox"/>	-----	-----	Blank spots in vision	-----	-----	-----
<input type="checkbox"/>	-----	-----	Brief periods of blindness	-----	-----	-----



- \_\_\_\_\_ 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:

	Early	Average	Late
Walking	-----	-----	-----
Language development	-----	-----	-----
Toilet training	-----	-----	-----
Overall development	-----	-----	-----

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Attention problems      | <input type="checkbox"/> Head injury         | <input type="checkbox"/> Muscle tightness or weakness                    |
| <input type="checkbox"/> Clumsiness              | <input type="checkbox"/> Hearing problems    | <input type="checkbox"/> Speech problems                                 |
| <input type="checkbox"/> Developmental delay     | <input type="checkbox"/> Hyperactivity       | <input type="checkbox"/> Vision problems                                 |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Psychological / behavior problems               |
| <input type="checkbox"/> Problems socializing    | <input type="checkbox"/> Drug use            | <input type="checkbox"/> 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.)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Allergies                            | <input type="checkbox"/> Epilepsy or seizures       | <input type="checkbox"/> Pneumonia        |
| <input type="checkbox"/> Asthma                               | <input type="checkbox"/> Fevers (104 F or higher)   | <input type="checkbox"/> Poisoning        |
| <input type="checkbox"/> Brain infection or disease           | <input type="checkbox"/> Heart problems             | <input type="checkbox"/> Polio            |
| <input type="checkbox"/> Cancer                               | <input type="checkbox"/> Immune system disease      | <input type="checkbox"/> Rheumatic fever  |
| <input type="checkbox"/> Cerebral palsy                       | <input type="checkbox"/> Kidney problems            | <input type="checkbox"/> Scarlet fever    |
| <input type="checkbox"/> Chicken pox                          | <input type="checkbox"/> Lung (respiratory) disease | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Colds (excessive)                    | <input type="checkbox"/> Measles                    | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Diabetes                             | <input type="checkbox"/> Meningitis                 | <input type="checkbox"/> Whooping cough   |
| <input type="checkbox"/> Encephalitis                         | <input type="checkbox"/> Oxygen deprivation         | <input type="checkbox"/> Psychological    |
| <input type="checkbox"/> Other diseases or disabilities:----- |   |   |

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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

26) How would you describe your nutrition as a child and adolescent?  
 Excellent \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

27) List the medications that were regularly given to you as a child:

Medication	Reason for medication
a) _____	_____
b) _____	_____
c) _____	_____
d) _____	_____

**ADULT MEDICAL HISTORY**

- 28) Check all that currently apply:
- |   |                          |                                      |
|---|--------------------------|--------------------------------------|
| _____ AIDS, ARC, or HIV+                | _____ Heart disease      | _____ Parkinson disease              |
| _____ Allergies                         | _____ Huntington disease | _____ Polio                          |
| _____ Arteriosclerosis (artery disease) | _____ Hypertension       | _____ Psychiatric problems           |
| _____ Arthritis                         | _____ Kidney disease     | _____ Radiation exposure/<br>Therapy |
| _____ Blood disorder                    | _____ Liver disease      | _____ Senility (Dementia)            |
| _____ Brain disease/infection           | _____ Lung disease       | _____ Stoke or TIA                   |
| _____ Cancer or chemotherapy            | _____ Malnutrition       | _____ Thyroid disease                |
| _____ Diabetes                          | _____ Meningitis         | _____ Venereal disease               |
| _____ Hazardous substance exposure      | _____ Multiple sclerosis | _____ Arrest or incarceration        |
| _____ Any other problems: _____         |                          |                                      |

29) Have you ever been placed on disability? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If yes, please explain: \_\_\_\_\_

30) List any medication you currently take (over-the-counter or prescription medication) and the dosage.

Medication	Dosage	Usage
a) _____	_____	_____
b) _____	_____	_____
c) _____	_____	_____
d) _____	_____	_____
e) _____	_____	_____





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
- \_\_\_\_\_ Tonio-clonic (Grand mal)
- \_\_\_\_\_ Atonic

\_\_\_\_\_ **UNCLASSIFIED TYPE**

\_\_\_\_\_ 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: \_\_\_\_\_



**Adult Neuropsychological History Questionnaire**

67) How would you describe your usual performance as a student in (please circle highest level):

High school                      College

Name of School	City/State	# Yrs Completed	Date Finished	Average Grade Degree (A,B,C,D)	Diploma
Grades 1-6 _____	_____	_____	_____	_____	_____
7-8/9 _____	_____	_____	_____	_____	_____
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:

	Presently using	Used in the past
<input type="checkbox"/> Amphetamines (inc. diet pills)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Barbiturates (downers, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cocaine or crack	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hallucinogenics (LSD, acid, STP, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Inhalants (glue, nitrous oxide, ect.)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Marijuana	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Opiate narcotics (heroin, morphine, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PCP (or angel dust)	<input type="checkbox"/>	<input type="checkbox"/>

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                   | Dizziness           | Loss of Balance       |
| Blackouts                   | Fainting            | Blurry Vision         |
| Poor Vision                 | Poor Hearing        | Noise in Ears         |
| Congested Nose              | Shortness of Breath | Sinus Problems        |
| Sore Throat                 | Coughing            | Rapid Heartbeat       |
| Irregular Heartbeat         | Heartburn           | Burping               |
| Nausea                      | Vomiting            | Gas                   |
| Bloated Stomach             | Constipation        | Diarrhea              |
| Urination Problems          | Weakness            | Menstruation Problems |
| Twitching                   | Trembling           | Cramps                |
| Numbness                    | Skin Problems       | Hyperventilation      |
| Sleep Problems              | Poor Appetite       | Overeat               |
| Weight Loss                 | Weight Gain         | Low Sex Energy        |
| 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)? \_\_\_\_\_

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