Adult Neuropsychological History Questionnaire

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

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<thead>
<tr>
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| ☐ | ____ | ____ | 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 from one activity to another activity
| ☐ | _____ | _____ | Other:_________________________________________________________________________________

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

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| ☐ | ____ | ____ | 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

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| ☐ | ____ | ____ | Difficulty telling right from left
| ☐ | _____ | _____ | Difficulty doing things I should automatically be able to do (e.g., brushing teeth, etc.)
| ☐ | _____ | _____ | Problems drawing or copying
### Adult Neuropsychological History Questionnaire

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

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

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

- □ _____ _____ 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

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### 7) SENSORY

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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
☐ □ _____ _____ Other: __________________________________________________________

8) PHYSICAL

✓ New Old

☐ □ _____ _____ Headaches Where: _________________ Intensity: ___________ Duration: __________
☐ □ _____ _____ Dizziness
☐ □ _____ _____ Nausea or vomiting
☐ □ _____ _____ Urinary incontinence
☐ □ _____ _____ Loss of bowel control
☐ □ _____ _____ Excessive tiredness
☐ □ _____ _____ Pain Location: __________________________________________________________
Duration: ____________________________________________________________________________
Intensity (0–None, 10–Worst its been) 1 2 3 4 5 6 7 8 9 10
How does it affect your emotions and activities: ____________________________________________
What helps the pain: ________________________________________________________________

9) BEHAVIOR

✓ Check all that apply to you in the past six months:

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)

Rate how severe:

Mild Moderate Severe

_____ _____ _____
_____ _____ _____
_____ _____ _____
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>
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<tr>
<td>Language development</td>
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<tr>
<td>Toilet training</td>
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<td></td>
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<tr>
<td>Overall development</td>
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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

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

- Allergies
- Epilepsy or seizures
- Pneumonia
- Asthma
- Fevers (104 F or higher)
- Poisoning
- Brain infection or disease
- Heart problems
- Polio
- Cancer
- Immune system disease
- Rheumatic fever
- Cerebral palsy
- Kidney problems
- Scarlet fever
- Chicken pox
- Lung (respiratory) disease
- Tuberculosis
- Colds (excessive)
- Measles
- Venereal disease
- Diabetes
- Meningitis
- Whooping cough
- Encephalitis
- Oxygen deprivation
- Psychological
- 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:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reason for medication</th>
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28) Check all that currently apply:

_____ AIDS, ARC, or HIV+
_____ Heart disease
_____ Parkinson disease
_____ Allergies
_____ Hypertension
_____ Huntington disease
_____ Arteriosclerosis (artery disease)
_____ Kidney disease
_____ Polio
_____ Arthritis
_____ Radiation exposure/Therapy
_____ Arteriosclerosis
_____ Brain disease
_____ Huntington disease
_____ Hypertension
_____ Polio
_____ Arteriosclerosis
_____ Brain disease/infection
_____ Kidney disease
_____ Radiation exposure/Therapy
_____ Arteriosclerosis
_____ Brain disease/infection
_____ Kidney disease
_____ Radiation exposure/Therapy
_____ Arteriosclerosis
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_____ Radiation exposure/Therapy
_____ Arteriosclerosis
_____ Brain disease/infection
_____ Kidney disease
_____ Radiation exposure/Therapy
_____ Arteriosclerosis
_____ Brain disease/infection
_____ Kidney disease
_____ Radiation exposure/Therapy

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.

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<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Usage</th>
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</table>
31) Do you have epilepsy or a seizure disorder?  _____ Yes  _____ No
   If yes, check the one you have been diagnosed with:
   PARTIAL  GENERALIZED  _____ UNCLASSIFIED TYPE
   _____ Simple partial (Jacksonian)  _____ Absence (Petit mal)
   _____ Complex partial (Psychomotor)  _____ Myoclonic
   _____ Partial evolving into generalized  _____ Clonic
   _____ Tonic  _____ Tonic–clonic (Grand mal)
   _____ Atonic
   _____ 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

MARRITAL 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:

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>Grades 1-6</th>
<th># Yrs Completed</th>
<th>Date Finished</th>
<th>Average Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>High school</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7-8/9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9/10-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-graduate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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, etc.)</td>
<td>____</td>
</tr>
<tr>
<td>____ Marijuana</td>
<td>____</td>
</tr>
<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 current conditions, and put an X next to those that are past conditions.)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>Herpes</td>
</tr>
<tr>
<td>Arthritis</td>
<td>High Blood Pressure</td>
</tr>
<tr>
<td>Asthma</td>
<td>Irritable Bowel Syndrome</td>
</tr>
<tr>
<td>Broken Bones</td>
<td>Kidney Disease</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>Liver Disease</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>Lupus</td>
</tr>
<tr>
<td>Cancer</td>
<td>Mental Illness</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>Pulmonary Disease</td>
</tr>
<tr>
<td>Colitis</td>
<td>Seizures</td>
</tr>
<tr>
<td>Concussion</td>
<td>Stroke</td>
</tr>
<tr>
<td>Congenital Abnormality</td>
<td>Thyroid Disease</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Emphysema</td>
<td>Ulcers</td>
</tr>
<tr>
<td>Gall Stones</td>
<td>Other___________________________</td>
</tr>
<tr>
<td>Head Trauma</td>
<td>Other___________________________</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>Other___________________________</td>
</tr>
<tr>
<td>Hemorrhoids</td>
<td></td>
</tr>
</tbody>
</table>

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 current conditions, and put an X next to those that are past conditions.)

- 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)?_____________________________________________________

____________________________________________________________________________
TRAUMA HISTORY

Prior to your 18th birthday:

Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

No___If Yes, enter 1 __

Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

No___If Yes, enter 1 __

Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

No___If Yes, enter 1 __

Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

No___If Yes, enter 1 __

Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

No___If Yes, enter 1 __

Were your parents ever separated or divorced?

No___If Yes, enter 1 __

Was your mother or stepmother:

Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

No___If Yes, enter 1 __

Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

No___If Yes, enter 1 __

Was a household member depressed or mentally ill, or did a household member attempt suicide?
No___If Yes, enter 1 __

Did a household member go to prison?

No___If Yes, enter 1 __