

NEUROPSYCHOLOGICAL  
ASSOCIATES, LLC



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## History Questionnaire

**Instructions:** Please fill out this form to help the psychologist learn useful information about you that would assist the evaluation or treatment process. **Please provide all the information requested.** Be assured that all information given on this form, as well as in treatment, is considered confidential and treated with respect and in a manner consistent with the privacy rules of the Health Insurance Portability and Accessibility Act (HIPAA). Please return this at the first visit if it was sent to you in advance.

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### PERSONAL INFORMATION:

Name: (Full name) \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone Number: Home: \_\_\_\_\_ Work: \_\_\_\_\_

(With area code)

Cell: \_\_\_\_\_ E-mail address: \_\_\_\_\_ ok to use: Y or N

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Handedness: Right \_\_\_\_\_ Left \_\_\_\_\_

Marital Status: (check one) Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

Other \_\_\_\_\_ ()

### REFERRAL INFORMATION:

Who referred you? \_\_\_\_\_

### PLEASE DESCRIBE, IN YOUR WORDS, WHY YOU ARE HERE:

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### Please describe your overall health:

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Name (s) of Primary AND other treating doctors:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_



**MEDICAL OR PSYCHOLOGICAL TESTING**

**PSYCHOLOGICAL:** Have you ever had psychological testing before? Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you had *Neuropsychological* testing before? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please give details (where, when, results):

\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL TESTS:**

Have you ever had an MRI or CT scan of the head? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, when? \_\_\_\_\_  
What were the results? \_\_\_\_\_

Have you ever had an EEG (brain wave scan)? Yes \_\_\_\_\_ No \_\_\_\_\_  
If so, when and what results were found:

Any other significant medical testing? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, of what and what were the results: \_\_\_\_\_

**ALCOHOL AND DRUG USE**

**How often do you drink alcoholic beverages:** (circle answer below)

Rarely or never                      1-2 times a month                      3-4 times a month  
Every week                              Several times a week                      every day or almost every day

Do you think you have a drinking problem?                      Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you ever been treated for alcoholism?                      Yes \_\_\_\_\_ No \_\_\_\_\_  
12 Step groups like AA: Have you attended?                      Yes \_\_\_\_\_ No \_\_\_\_\_ Now or in the past?  
Other 12 Step groups? Is so, which one (s): \_\_\_\_\_

**Do you use any recreational drugs or prescription medications that are not prescribed to you? Yes \_\_\_\_\_ No \_\_\_\_\_**

If yes, how often: please circle

Rarely or never                      1-2 times a month                      3-4 times a month  
Every week                              Several times a week                      every day or almost every day

**Please circle** any of the following recreational drugs that you use or have used in the past:

Marijuana                      Cocaine                      LSD                      Amphetamines  
Heroin                              Quaaludes                      Crack Cocaine                      Other: \_\_\_\_\_

**Smoking:** Do you now smoke cigarettes? Yes \_\_\_\_\_ No \_\_\_\_\_  
How often/how many a day? \_\_\_\_\_ Since when? \_\_\_\_\_  
If you smoked in the past, when did you quit? \_\_\_\_\_

## **FAMILY HISTORY**

What is your mother's name? \_\_\_\_\_ Is she still living? \_\_\_\_\_

If deceased, when? \_\_\_\_\_ Cause? \_\_\_\_\_

What is your father's name? \_\_\_\_\_ Is he still living? \_\_\_\_\_

If deceased, when? \_\_\_\_\_ Cause? \_\_\_\_\_

Brothers or sisters? Please list names and ages: \_\_\_\_\_

Spouse's name & age \_\_\_\_\_ how long married/together? \_\_\_\_\_

Do you have any children? \_\_\_\_\_ If so, please list their names and ages:

With whom do you live now? \_\_\_\_\_

If divorced, separated or widowed, how long? \_\_\_\_\_

Married how long prior to change? \_\_\_\_\_

**Is there a *family history* of:** (check any that apply and write details here)

\_\_\_\_\_ Mental retardation \_\_\_\_\_ Neurological problems (stroke, etc)

\_\_\_\_\_ Learning Disabilities \_\_\_\_\_ Psychiatric/psychological problems

## **SCHOOL AND WORK HISTORY**

### **Education**

What is the highest grade or academic level you completed? (Check one):

\_\_\_\_\_ some high school (last grade finished: \_\_\_\_\_; what year did you leave school? \_\_\_\_\_)

\_\_\_\_\_ High School Graduate (year? \_\_\_\_\_)

\_\_\_\_\_ Vocational - tech or trade school (what trade/skills? \_\_\_\_\_)

\_\_\_\_\_ Some College (estimated # of credits obtained: \_\_\_\_\_)

\_\_\_\_\_ College degree: \_\_\_\_\_ Associate's \_\_\_\_\_ Bachelor's (what was your major? \_\_\_\_\_)

\_\_\_\_\_ Post college: \_\_\_\_\_ Some grad school \_\_\_\_\_ Master's \_\_\_\_\_ Post Master's  
(Details of post college academic work)

Did you like school? \_\_\_\_\_ what was your average in school? \_\_\_\_\_

Do you hope to resume or continue your education? \_\_\_\_\_

In what area (s)? \_\_\_\_\_

**Work**

*Are you working now?* \_\_\_\_\_ *Yes* \_\_\_\_\_ *No*

What is your current or most recent occupation? \_\_\_\_\_

How long at this job? \_\_\_\_\_ Reason for leaving? \_\_\_\_\_

Name, address of your employer \_\_\_\_\_

Do you/did you enjoy your work? \_\_\_\_\_ *Yes* \_\_\_\_\_ *No*      What did you like about it?

\_\_\_\_\_

What other jobs have you had in the past?

\_\_\_\_\_

If you aren't working now, do you want to return to work? \_\_\_\_\_

Do you think you will have any difficulties returning to work (if your are NOT working now)? If so, what are they? \_\_\_\_\_

What is/was your typical annual income, approximately? \_\_\_\_\_

**Leisure Activities**

How do you spend your leisure time? \_\_\_\_\_

What hobbies or interests do you have? \_\_\_\_\_

**Have you had to stop doing or change how you're doing any of these activities since your illness/accident?** \_\_\_\_\_

**What else would be useful for us to know about you to help you?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

THANKS FOR COMPLETING THIS QUESTIONNAIRE.