Adult Neuropsychological Questionnaire

Name: Date of Birth: Age:

Please circle pronouns we should use for you: he/him/his she/her/hers they/them/their

Education Level Completed: (circle)

<8th 9th 10th 11th GED 12th
1 semester college 1yr college 2yrs college/AS/AA 3yrs college 4 years college/BA/BS/BSN
Master's degree
Certificate of advanced study
Doctoral level degree

Dominant Hand: Right Left Ambidextrous

Native Language: Where did you grow up?:

Please complete the following symptom inventory. Circle all that apply as current symptoms/concerns

Attention/concentration concerns	Feeling sad or depressed	Episodes of unconsciousness
Memory concerns/Forgetfulness	Anxiety, excessive worry	Periods of loss of time
Difficulty remembering names	Irritability	Sleep problems
Word finding difficulty	Anger issues	Headaches
Difficulty putting thoughts into words	Mood swings	Muscle pain
Reading comprehension difficulty	Relationship problems	Joint pain
Listening comprehension difficulty	Stress	Other pain
Spelling difficulty	Social difficulty	Balance difficulty
Misplacing things	Lack of social supports	Spinning sensation
Problems with visual spatial skills	Grief/loss	Lightheadedness/ Dizziness
Getting lost	Suicidal thoughts	Increased clumsiness
Difficulty with math	Violent thoughts	Difficulty walking
Difficulty with handwriting	Fever	Weakness
Problem solving difficulty	Chills	Bumping into things
Difficulty organizing things	Night Sweats	Falling more frequently
Difficulty with multi-tasking	Hot flashes	Changes in hearing
Difficulty planning things	Feeling unusually hot	Changes in sense of smell
Confusion	Feeling unusually cold	Changes in sense of taste
Slow to process information / foggy	Ringing in ears	Change in perception of touch

Loss of appetite	Swallowing difficulty	Blurred vision
Increased appetite	Hoarseness	Double vision
Significant change in weight	Coughing	Eye strain
Heavy snoring	Shortness of breath	Light sensitivity
Waking to catch breath	Chest pain	Noise sensitivity
Excessive daytime fatigue	Palpitations	Other:
Nausea	Racing heart	
Vomiting	Fainting	
Diarrhea		

Have you had COVID-19? Yes/No. If yes, do you have any lingering symptoms?

Have you been vaccinated for COVID-19? Yes/ No If yes, did you have any problematic side effects?

Other Medical/Health History

Do you have the following or a history of the following? (Check all that apply)	Current ✔	Past history of…✔	Specifics…
Birth trauma			
Huntington's Disease			
Spina Bifida			
Cerebral Palsy			
Learning Disability			
ADHD/ADD			
Vision condition			
Eating disorder			
Speech disorder			
Hearing disorder			
Frequent ear infections			
Asthma			
COPD			
Seizure Disorder			
Cancer			
Thyroid Condition			
Meningitis or Encephalitis (circle)			

Spinal cord injury			
Stroke			
Cerebrovascular disease			
TIAs			
Heart Disease			
History of heart attack			
Hypertension (high blood pressure)			
Dyslipidemia, High cholesterol			
Migraines			
Non migraine headaches			
Diabetes			
Multiple sclerosis			
Systemic Lupus			
Dementia			
HIV+/ AIDS			
Hepatitis or other liver disease			
Toxic Exposure (e.g., lead, carbon monoxide)			
Lyme Disease or other tick borne disease			
Parkinson's Disease			
Arthritis			
Fibromyalgia or other chronic pain			
Sleep apnea			
Other sleep disorders			
Gastrointestinal disorder			
Depression			
Anxiety problems			
OCD, panic disorder, agoraphobia			
Tourette's or other tic disorder			
Bipolar Disorder "manic depression"			
Schizophrenia or Schizoaffective disorder			
Abuse or neglect			
Posttraumatic Stress Disorder			

Postpartum depression			
Alcoholism			
Drug abuse or dependence			
Autism spectrum disorder (e.g., Aspergers)			
Mental Retardation/Intellectual Disability			
Neurofibromatosis			
Neuromuscular disease			
Concussions/head injury/brain injury			

List Allergies:

List all surgeries and year of procedure:

List other recent illnesses/injuries:

List date & results of brain scans (e.g., MRI or CT) and EEG not already described above:

What are your current medications/supplements? Please note dose and frequencies.

What is your frequency of cardiovascular/aerobic exercise (of approximately 30 minutes duration)?

Typical amount and quality of sleep per night:

Family Medical History: Circle any conditions experienced by family members and note who:

Heart Disease	Stroke	Transischemic Attacks (TIAs)
Alcoholism	Drug Abuse	Cancer
Depression	Anxiety	Obsessive Compulsive Disorder
Schizophrenia	Bipolar Disorder	Schizoaffective Disorder
Other mental illness:_____		
ADD/ADHD	Learning Disability	
Seizure Disorder	Alzheimer's type Dementia	Other Dementia
Migraines	Parkinson's	Huntington's
ALS/Lou Gehrig's Disease	Autism spectrum disorder	Other Neurologic:

Substance Use	How many servings or uses per day on average	How many servings per week on average	✔ if prior problem but not current
Caffeinated (soda, tea, coffee, sport drinks)			
Alcohol: Type:_____ One serving of wine= 5oz. For beer= 12oz. Distilled liquor= 1.5oz			

Marijuana (including medical)			
Nicotine/Tobacco			
Other:			

Childhood History
Briefly describe your family and growing up experience:

Were there any problems with your birth or early development?

Educational and Work History

Did you receive Special Education? Yes/No When Started?_____Ended?_____

Did you repeat any grades? Yes/No Which? Why?

Best Subject/s?_____ Hardest Subject/s?_____

Average grades during middle school? (Circle, add comments)

Average (B to C)

Above average A/B to A)

Below average (C- and below)

Average grades during high School? (Circle, add comments)

Average (B to C)

Above average A/B to A)

Below average (C- and below)

Did you attend college? Y/N. If so, what was your GPA? ____

Did you attend graduate school? Y/N. If so, what was your GPA? ____

Work History

Circle status

Retired PT Employed: List current job:

FT Employed: List current job: Self Employed: List current job:

Unemployed Disabled

Previous positions held:

Have you been let go from positions? If yes, why?

Are you having trouble at work currently? If yes, why?

Military Service

Branch _____ Years served_____ Job/s_____

Highest Rank _____ Type of Discharge_____Combat (zone)? Y/N

Adult Family and Social History

Current relationship status: (select all that apply)

Single/Never married Partnered Partnered/Cohabiting

Married Separated Divorced Widowed

If currently partnered or married, how many years have you been together?

Quality of current relationship (select all that apply)

Healthy Loving Supportive Emotionally distant Complicated Strained Abusive Other:

Do you have children? If yes, how many and what are their ages?

Do you have grandchildren? If yes, how many and what are their ages?

How many people live in your household full time or part time?

Note relationships of those who live in your home:

Are you satisfied with your social life?

What do you like to do with your free time?

Please indicate date form was completed_____

Please bring a list of current medications and supplements at the time of your appointment. Include dose and frequency.
Thank you!