GRW Neuropsychology History Questionnaire

Patient's name _____

Current age _____ Date of birth _____

Handedness ☐Right ☐Left Ethnicity _____

Gender ☐Male ☐Female Marital status _____

Who referred you for cognitive evaluation? _____

What is your understanding of why this evaluation was requested? _____

_____

_____

Have you ever undergone neuropsychological or psychological testing in the past? _____

If yes, please note date and reason for testing: _____

Check highest level of education ***completed***:

☐Some high school – specify: _____

☐GED

☐High School Diploma

☐Some college – specify: _____

☐Associate's degree

☐Bachelor's degree

☐Master's degree

☐Doctoral degree

☐Other: _____

Have you ever been held back or required to repeat a grade? ☐YES ☐NO

If yes, please note grade(s) and reason: _____

_____

Did you attend special education classes? ☐YES ☐NO

If yes, please note grade(s) and subject(s): _____

_____

Did you have an IEP or 504 Plan? ☐YES ☐NO

If yes, please specify: _____

_____

Were you ever diagnosed with a learning disability or ADHD? ☐YES ☐NO

If yes, please specify: _____

_____

Check present employment status:

☐Part-time employment ☐Full-time employment ☐Unemployed

☐Disability insurance ☐Worker's compensation ☐Retired

Document type of current or most recent job, including dates: _____

_____

Are you presently involved in any litigation? ☐YES ☐NO

If yes, please describe: _____

List all medical problems for which you are currently treated:

1.
2.
3.
4.
5.

Other:

Have you had a CT or MRI scan of the head or brain? ☐YES ☐NO

If yes, when and where? _____

Have you had an EEG? ☐YES ☐NO

If yes, when and where? _____

Check any medical conditions relevant to you and age of onset:

☐High blood pressure____	☐High cholesterol____	☐Heart disease____	☐COPD____
☐Type 1 diabetes____	☐Type 2 diabetes____	☐GERD____	☐Sleep apnea____
☐Brain injury____	☐Concussion____	☐Seizures____	☐Spells____
☐Cancer____	☐Chemotherapy____	☐Radiation____	☐Stroke____

Check any of the following conditions or symptoms that are relevant to you:

- ☐ Fatigue
- ☐ Low energy
- ☐ Loss of appetite
- ☐ Sleep disturbance
- ☐ Chronic pain
- ☐ Numbness/tingling
- ☐ Weakness
- ☐ Problems with balance
- ☐ Falls
- ☐ Tremor
- ☐ Stiffness
- ☐ Difficulty swallowing
- ☐ Restless leg syndrome
- ☐ Acting out dreams
- ☐ Urinary urgency
- ☐ Urinary incontinence
- ☐ Dizziness or fainting
- ☐ Double vision

Check areas of cognitive change or concern:

☐Memory loss	☐Forgetting conversations	☐Difficulty finding words
☐Repeating self	☐Misplacing possessions	☐Getting lost
☐Inattention	☐Reduced focus or concentration	☐Distractibility
☐Slowed thinking		

When did you or someone else ***first*** notice these changes? _____

_____

Has there been any decline over time? ☐YES ☐NO

If yes, check: ☐gradual ☐steep ☐fluctuating

List all individuals living in the home with you: _____

_____

Check all tasks that you currently conduct independently:

☐Dressing ☐Bathing ☐Driving ☐Managing medications
☐Shopping ☐Cooking ☐Managing appointments ☐Managing finances

Describe any recent changes in behavior: _____

_____

Describe any recent changes in personality: _____

_____

Describe your *current* mood: _____

_____

Check any emotional symptoms that you *currently* experience:

☐Sadness ☐Tearfulness ☐Depression ☐Anxiety/nerves
☐Worry ☐Stress ☐Panic ☐Restlessness
☐Anger ☐Irritability ☐Nightmares ☐Flashbacks
☐Hallucinations ☐Suspiciousness ☐Self-harm ☐Thoughts of suicide
☐Loss of interest ☐Social isolation ☐Loneliness ☐Emotional sensitivity

At what age did you *first* seek mental healthcare? _____

List reason(s) for treatment: _____

For how long have you been seeing your current psychiatrist? _____

Are you currently treated by a psychologist or therapist? ☐YES ☐NO

If yes, note type of treatment and monthly frequency: _____

_____

Check if ever diagnosed with:

☐Depression ☐Suicide attempt ☐Anxiety disorder ☐Panic attacks
☐Post-traumatic stress disorder (PTSD) ☐Obsessive Compulsive Disorder (OCD)
☐Bipolar I disorder ☐Bipolar II disorder ☐Schizophrenia ☐Schizoaffective disorder
☐Suicide attempt ☐Opioid addiction ☐Alcohol addiction ☐Other drug addiction

Type, amount and weekly frequency of alcohol use: _____

_____

Type, amount and weekly frequency of recreational drug use: _____

_____

Approximate daily tobacco use: _____PPD

Check any conditions that run in your family and indicate your relationship to the individual:

- ☐ High blood pressure_____
- ☐ Diabetes_____
- ☐ Heart disease_____
- ☐ Stroke_____
- ☐ Cancer_____
- ☐ Epilepsy or seizures_____
- ☐ Multiple Sclerosis_____
- ☐ ALS_____
- ☐ Dementia_____
- ☐ Alzheimer's disease_____
- ☐ Parkinson's disease_____
- ☐ Huntington's disease_____
- ☐ Alcoholism_____
- ☐ Addiction_____
- ☐ Depression_____
- ☐ Suicide_____
- ☐ Anxiety_____
- ☐ Bipolar disorder_____
- ☐ Schizophrenia or psychosis_____
- ☐ ADHD_____

Please provide any additional information that you feel may be useful: _____

_____

_____

Name of person completing this form and relationship to patient: _____

_____

Daily Medications	**Dosage**	**Times Per Day**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		