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CLINICAL PSYCHOLOGY • NEUROPSYCHOLOGY • FORENSIC CONSULTATION

NEUROPSYCHOLOGICAL QUESTIONNAIRE

Name: _____

Date of Birth: _____**Sex:** _____ **Today's Date:**_____

Occupation: (If retired, primary occupation while employed):

_____

Are you right-handed or left-handed? _____

Highest level of education achieved: _____

Please answer the following questions, describing problem areas in the space provided. Your assistance is very important so that your evaluation can be as complete as possible. Thank you.

SENSORY-MOTOR:

Have you had any changes in the way you walk? _____

Lately, have things dropped out of your hands? _____

Do your hands tremble sometimes? _____

Has your handwriting changed lately? _____

Have you had any dizzy spells lately? _____

Do you lose your balance easily? _____

Have you had any changes in your vision? _____

Has your sense of smell changed recently? _____

Has your handwriting changed lately? _____

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SPEECH/LANGUAGE:

Do you slur your words sometimes? _____

Has the way you talk changed? _____

Are there times when you want to say something but have difficulty getting the words out?

_____

MEMORY:

Has your memory changed? _____

If so, please describe these changes. _____

_____

When did you start noticing these changes? _____

Who else has noticed these changes? _____

Do you sometimes have trouble remembering the names of common objects? _____

If so, how often? _____

Sometimes, have you started to say something and then forgotten what it was? _____

Do you have often trouble remembering recent events, appointments or commitments? If so, please describe: _____

_____

Do you have trouble remembering events from your youth or earlier adult years? _____

ATTENTION/CONCENTRATION:

Do you have any trouble concentrating on daily activities? _____

Do you find it harder to recall things that you have just read? _____

Do others often complain that you frequently do not pay attention? _____

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TYPICAL DAILY ROUTINES:

Have there been any changes in your sleep pattern in the last year? If so, please describe.

_____

Do you have trouble falling asleep or staying asleep? _____

Have you gained or lost weight in the past few months without diet? _____

Have there been any changes in your sexual responsiveness? _____

Do you feel a general lack of motivation? _____

Recently, have you had a thought that went on and on in your mind and you couldn't stop it? _____

MOOD:

Do you often feel worried or anxious? _____

Have you been feeling depressed? _____

If so, for how long? _____

Have you, or other family members, had periods of significant emotional unrest that have required treatment by a mental health professional? If so, please describe. _____

_____

MEDICAL HISTORY:

Are you currently suffering from and/or are being treated for any serious medical illnesses? If yes, please describe.

_____

Have you had any serious medical illnesses in the past? If yes, please describe. _____

_____

What medications are you currently taking? _____

_____

:

Do you suffer from headaches? _____ If so, please describe their location and severity? _____

If so, what makes them better? _____

What makes them worse? _____

FAMILY MEDICAL HISTORY:

Has anyone in your family had a neurological illness? _____ If yes, who and when? _____

ALCOHOL AND DRUG USE:

Alcohol consumption per day? _____

Has your consumption of alcohol changed lately? _____

Do you use any non-prescription drugs? _____

TOXIC EXPOSURE:

Do you (or did you) regularly come in contact with any chemicals at your work? _____

If so, which ones and for how long? _____

ACQUIRED INJURIES:

Have you been in any accidents? (If so, please describe.) _____

_____

Have you ever sustained any serious head injuries? If so, please describe nature of injury and when it took place. _____

_____

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