PERSONAL HISTORY QUESTIONNAIRE

Enclosed you will find several pages of questions that we want you to answer about yourself. Please answer them to the best of your ability, as completely and honestly as you can.
Return the completed questionnaire to this office at least two weeks before your appointment.

Name ______________________________ Today's date ____________________

Mailing address ____

Home phone ______________ Cell phone ______________ Work phone ______________

You may get help with this questionnaire if you need it, because we are interested in having complete and accurate information.

Helped by ______________________ Relationship ______________________

Person to be notified in case of emergency: Name ____________________ Phone __________

Relationship (e.g., spouse, parent, guardian, etc.) ________________

Are you your own guardian? Yes / No Does someone hold Power of Attorney for you? Yes / No

Name of guardian (or person with Power of Attorney) ________________ Phone __________

Name and address of family physician ______________________________________

____

Name of person who referred you here ______________________________

What is your understanding of the reason for this examination? ______________________

____

Do you have a disability or special need for which you require accommodation for this examination, such as severe visual or hearing problems, severe pain, problems with mobility, severe fatigue, etc.?

Please describe ____

When complete, return to:
NEUROPSYCHOLOGY SERVICE, P.A.
277 State St., Suite 2A
Bangor, ME 04401

GENERAL INFORMATION:

Date of Birth ________________ Age_____ Gender M / F Place of Birth ________________ Native language ______________

Hand dominance_____ Marital status _____ Spouse/partner's first name ______________________ How long married/together?_______

Children (#, ages) ____

If this is not your first marriage or committed relationship, please give first names of prior spouses/partners and how long you were together:

Name______________________________ Years together_______ # Children__________

Name______________________________ Years together_______ # Children__________

Name______________________________ Years together_______ # Children__________

FAMILY HISTORY:

Where did you spend most of your growing-up years? _________________________ Were your parents married during that time?_______

Father: Present age_____ Yrs of Education _____ Occupation____________________________ Hand he writes with_____

(If deceased, age at death_____ Cause of death____________________)

Mother: Present age____ Yrs of Education _____ Occupation____________________________ Hand she writes with_____

(If deceased, age at death_____ Cause of death____________________)

Siblings: first names and present ages ____

Was there much conflict, abuse or dysfunction in your family when you were growing up? _____ Please describe briefly _______________

____

Have *close relatives* (parent, sibling, your children) had any of the following chronic or serious medical problems? If so, indicate who:

- ❑ Cancer
- ❑ Huntington's disease
- ❑ Stroke
- ❑ Bipolar disorder
- ❑ Diabetes
- ❑ Other genetic disorder
- ❑ Dementia / Alzheimer's
- ❑ Schizophrenia
- ❑ Heart attack/heart disease
- ❑ Lung disease / asthma
- ❑ Alcohol / drug abuse
- ❑ Mental retardation
- ❑ High blood pressure
- ❑ Epilepsy / seizures
- ❑ Depression
- ❑ ADD / ADHD
- ❑ Thyroid disease
- ❑ Multiple sclerosis
- ❑ Anxiety
- ❑ Learning disabilities

EDUCATION HISTORY:

Circle highest year of grade school or high school you *completed:* 1 2 3 4 5 6 7 8 9 10 11 12

Any trouble learning to read?______ Write? ______ Do math? _______ Receive special services? _____ If yes, what for? ______________

Repeat any grades? _______ If yes, which ones? _______ Year left or graduated high school________

Circle highest year of college you *completed:* None 1 2 3 4 Master's Doctoral Professional (e.g., law, medicine, dentistry)

College attended ___________________________ Major ________________________ Grade average _____ Year left/graduated ___

College attended ___________________________ Major ________________________ Grade average _____ Year left/graduated ___

Additional education (e.g., technical school, specialized training, etc.)____

WORK HISTORY:

What is your occupation or usual type of work? ______________________________ For how many years?________

Present or most recent job: Title______________________________ Employer______________________

Dates worked there______________ Reason for leaving (if not working now)______________________

Previous job: Title______________________________ Employer______________________

Dates worked there______________ Reason for leaving ______________________

Previous job: Title______________________________ Employer______________________

Dates worked there______________ Reason for leaving ______________________

Previous job: Title______________________________ Employer______________________

Dates worked there______________ Reason for leaving ______________________

Did/do you generally enjoy your work? Yes No Do/did you get positive job evaluations?_______

Any particular problems at work?_____ Please specify ______________________________

If you are not working now, give reason ______________________________

MILITARY SERVICE:

Branch of military______________ #Years served________ See combat?________ Type of discharge______________

Job in military ______________________________ Any problems? ______________________

LEGAL HISTORY:

Ever been arrested? ____ When?________ Explain ______________________ Have you ever been convicted of a felony?____

If yes, please explain______________________________ Ever serve time in jail or prison? ____________

Are you currently involved in any lawsuits or legal actions? ______ Please explain ______________________

SOCIAL/RECREATIONAL HISTORY:

What types of activities do you participate in for recreation?______________________________ How often? _____

Do you regularly attend social functions? _______ Do you spend regular/frequent time with friends ?_______ Exercise regularly? ____________

MEDICAL/MENTAL HEALTH HISTORY:

Check any of the following that <u>you</u> have had. Please also give date or approximate age when it began or was diagnosed.

❑ Cancer	❑ Huntington's disease	❑ Dementia / Alzheimer's	❑ Schizophrenia
❑ Diabetes	❑ Other genetic disorder	❑ PTSD	❑ Mental retardation
❑ Heart attack/heart disease	❑ Lung disease / asthma	❑ Depression	❑ ADD / ADHD
❑ High blood pressure	❑ Epilepsy / seizures	❑ Anxiety	❑ Learning disabilities
❑ Thyroid disease	❑ Multiple sclerosis	❑ Bipolar disorder	❑ Other ____________
❑ Sleep apnea / Insomnia		❑ Victim of abuse or severe neglect	

❑ Drug/alcohol abuse. Please describe____

____

❑ Head injury with loss of consciousness. Please describe (date, circumstances) ____________________

____

❑ Stroke, brain tumor, or brain infection (meningitis or encephalitis) Please describe (date, symptoms)______________

____

❑ Major surgery for ____

❑ Treatment for emotional problems. What were you treated for?______________________________

What kind of treatment? (please circle all that apply) Medications / Counseling / Hospitalization / Other____________

If hospitalized, please give details (when, where) _____________________________________

Name of current psychiatrist and/or therapist _______________________________________

❑ Other medical or psychiatric issues ____

Give name(s) of doctors seen in last 6 months and any involved agencies:

Doctor's name______________________________ Specialty____________________

Doctor's name______________________________ Specialty____________________

Doctor's name______________________________ Specialty____________________

Agency __________________________________ What for? ________________________

Agency __________________________________ What for? ________________________

Please list all medications that you currently take (prescribed or over-the-counter):

Medicine	Dosage	For (illness)

[Attach extra sheets if necessary to list all medications]

Allergies:____

# of cigarettes you smoke / day________ How many years have you smoked?________ If you quit, how many years since you smoked?________

Typical amount of alcohol you consume in one: day / week / year ________ What type?________________ Any arrests for OUI?__________

Any recreational drugs used now?_____What type?____

How frequently do you use these drugs?____________________

ACTIVITIES OF DAILY LIVING:

Have you experienced any difficulties in any of the following areas of functioning in the last 6 months? If yes, check:

❑ Eating ❑ Daily hygiene ❑ Getting dressed ❑ Bathing ❑ Speech/Communication ❑ Socializing

❑ Cleaning ❑ Cooking ❑ Shopping ❑Handling money/finances ❑ Reading/Writing ❑ Going up/down stairs

Do you drive a motor vehicle? _______ Any problems driving?____________________ Is your license current? ____________

FEELINGS ABOUT EVALUATION (please check as many as apply to your current feelings and situation):

❑ I am having a few problems, but they are no worse than other people my age.

❑ I am having a few problems, and I am concerned about them.

❑ I am having serious problems.

❑ Other people do not seem to understand or appreciate how difficult things are for me right now.

❑ I am greatly relieved that someone is finally taking me seriously.

❑ My problems all started after my injury (or illness: ____________________).

❑ My problems are so bad that I have a hard time imagining how I can go on living. I just can't stand going on like this.

❑ This whole evaluation is a waste of my time.

ADDITIONAL INFORMATION: Please give any other information about yourself that you think is important for us to know

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PLEASE COMPLETE THE PROBLEM CHECKLIST ON THE FOLLOWING PAGES →→→

ADULT PROBLEM CHECKLIST

Please carefully review the following list of problems. If any of them apply to you ***currently or in the last month***, please check the level of severity (mild, moderate or severe). ***If there are no problems, leave the boxes blank.***

	Mild Problem	Moderate Problem	Severe Problem	Comments
SLEEP				
Falling asleep	☐	☐	☐	________
Restless, poor sleep	☐	☐	☐	________
Nightmares	☐	☐	☐	________
Getting up in morning	☐	☐	☐	________
ENERGY / FATIGUE				
Too much energy	☐	☐	☐	________
Low energy/stamina	☐	☐	☐	________
APPETITE / WEIGHT				
Not eating enough	☐	☐	☐	________
Eating too much	☐	☐	☐	________
Weight (over/under)	☐	☐	☐	________
Poor food choices	☐	☐	☐	________
BOWELS / BLADDER				
Accidents/"soiling"	☐	☐	☐	________
Diarrhea/constipation	☐	☐	☐	________
PAIN				
Frequent or severe pain	☐	☐	☐	*Where?*________
Headaches	☐	☐	☐	________
Joint pain	☐	☐	☐	________
Back pain	☐	☐	☐	________
Other	☐	☐	☐	________
HEARING				
Hard of hearing	☐	☐	☐	________
Overly sensitive	☐	☐	☐	________
VISION				
Poor acuity/blurriness	☐	☐	☐	________
Light sensitivity	☐	☐	☐	________
BALANCE/COORDINATION				
Using tools/utensils	☐	☐	☐	________
Dizziness/vertigo	☐	☐	☐	________
Balance	☐	☐	☐	________
Walking	☐	☐	☐	________
SEXUAL				
Dysfunction/pain	☐	☐	☐	________
Problematic sexual behaviors	☐	☐	☐	________

	Mild Problem	Moderate Problem	Severe Problem	Comments
MEMORY				
Recalling old information	☐	☐	☐	________
Recalling recent information	☐	☐	☐	________
Recalling names	☐	☐	☐	________
Remembering dates, events, appointments	☐	☐	☐	________
Remembering what I read	☐	☐	☐	________
Losing things	☐	☐	☐	________
ATTENTION / CONCENTRATION				
Staying focused on task	☐	☐	☐	________
Distractible	☐	☐	☐	________
Needing repetition	☐	☐	☐	________
Completing tasks/projects	☐	☐	☐	________
SPEECH / LANGUAGE				
Thinking of words, names	☐	☐	☐	________
Expressing thoughts	☐	☐	☐	________
Understanding conversation	☐	☐	☐	________
Pronunciation	☐	☐	☐	________
EXECUTIVE				
Difficulty organizing belongings	☐	☐	☐	________
Difficulty organizing tasks	☐	☐	☐	________
Can't make decisions	☐	☐	☐	________
Procrastinates	☐	☐	☐	________
Difficulty with changes	☐	☐	☐	________
Problems getting started on tasks	☐	☐	☐	________
SCHOOLING [current students]				
Reading	☐	☐	☐	________
Writing	☐	☐	☐	________
Math	☐	☐	☐	________
Taking notes	☐	☐	☐	________
Attendance	☐	☐	☐	________
Taking tests	☐	☐	☐	________
Larger projects (such as reports, term papers, etc.)	☐	☐	☐	________
WORK				
Poor evaluations	☐	☐	☐	________
Conflict with supervisors	☐	☐	☐	________
Conflict with co-workers	☐	☐	☐	________
Productivity, speed	☐	☐	☐	________
Stress at or about work	☐	☐	☐	________
SOCIAL				
Verbal conflict with others	☐	☐	☐	________
Physically aggressive	☐	☐	☐	________
Choices of friends	☐	☐	☐	________
Gullible, easily influenced	☐	☐	☐	________
Shy	☐	☐	☐	________

	Mild Problem	Moderate Problem	Severe Problem	Comments
Isolated, lonely	☐	☐	☐	________
Impulsive, disinhibited	☐	☐	☐	________
Making/keeping friends	☐	☐	☐	________
Marriage/partnership	☐	☐	☐	________
Poor boundaries	☐	☐	☐	________
EMOTIONAL				
Anger/irritability	☐	☐	☐	________
Temper tantrums	☐	☐	☐	________
Depression	☐	☐	☐	________
Nervousness, worry	☐	☐	☐	________
Fears, phobias	☐	☐	☐	________
Feelings of inferiority	☐	☐	☐	________
Moody, ups & downs	☐	☐	☐	________
Suicidal thoughts	☐	☐	☐	________
Hallucinations	☐	☐	☐	________
Unusual thoughts (delusions, paranoia)	☐	☐	☐	________
UNUSUAL OR REPETITIVE BEHAVIORS				
Odd mannerisms or habits	☐	☐	☐	________
Tics	☐	☐	☐	________
Obsessive or compulsive behaviors	☐	☐	☐	________
Hoarding	☐	☐	☐	________
Unusual movements (e.g., rocking, hand flapping)	☐	☐	☐	________

COMMENTS: Please describe any other problems you experience that are not listed above.

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When completed, please return to:

Neuropsychology Service, P.A.
277 State St., Suite 2A
Bangor, ME 04401