Pre-Neuropsychological Evaluation Questionnaire

If the form is not completed by the patient, please provide the name and relationship to the patient of the individual completing the form.

Reporting Individual's Name

First Name Last Name

Relationship to Patient

Phone Number

Area Code Phone Number

INSTRUCTIONS FOR COMPLETING

Please answer the following questions about your health and history. Although this form is lengthy, it is designed to be very thorough. Completing this information before your appointment will greatly assist the doctor to best use your assessment time with her/him by enabling a more detailed focus.

Demographics

Patient's Name *

First Name Middle Name Last Name

Patient's Date of Birth *

Day Year

Patient's Sex *

Patient's Handness *

Patient's Ethnicity *

Patient's Primary Doctor

Doctor's Name

Doctor's Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Doctor's Phone Number

Area Code Phone Number

Doctor's Fax Number

Area Code Phone Number

May we contact your doctor?

Yes	No

Referral Information

Who referred you for this evaluation? *

If referred by a specific physician, mental health care provider, or other specialist, please provide his/her name, specialty, and contact information below:

Name of referral *

Specialty

Address of referral

Street Address

Street Address Line 2

City	State / Province

Postal / Zip Code

Referral's Phone Number *

Area Code	Phone Number

Referral's Fax Number

Area Code Phone Number

May we contact the provider who referred you? *

Yes No

Presenting Problem

Please briefly describe what problem(s) with thinking are you experiencing *

Did these changes have an abrupt onset? *

Yes No

Did these changes have a gradual onset? *

Yes No

Please describe how long you or the patient has been experiencing these problems and a brief description of the course (for example, gradual onset starting 3 years ago but a more noticeable decline in the past 6 months). *

Have you noticed any of these additional symptoms? Please check those that apply to you.

Attention *

Easily distracted

Difficulties staying on task

None of the above

Memory *

Asking the same question repeatedly
Difficulties with making or keeping appointment
Forgetting why you went into a room
Forgetting where things are in the kitchen
None of the above

Language *

Trouble summoning words (the words feels like it is on the tip of your tongue)
Stopped reading
Mispronouncing or using wrong words
Handwriting has deteriorated
Trouble recalling names of long time aquaintances
None of the above

Visuospatial Function *

Confused or disoriented in stores or malls
Getting lost easily even on familiar routes
Trouble finding the care in the parking lot
Difficulty driving*
None of the above

*** If you check "difficulty driving" above, have you been in a motor vehicle accident?**

Yes**   No

****If you have been involved in a motor vehicle accident, please describe when and how this occurred.**

Executive Function *

Feel unorganzied
Lacking motivation
Increased difficulty multitasking

Personality Changes
Embarrassing or inappropriate in social gatherings
Difficulties with hygiene/bathroom use
Difficulties with negative evaluations at work
None of the above

Praxis *

Difficulties using household items
Trouble dressing (i.e., two socks on one foot, shirt on backwards)
None of the above

Vision *

Blurred vision
Groping for door handles
Bumping into walls or doorways when walking
None of the above

Emotional *

Sadness
Anxiousness
Social problems
None of the above

What are your typical daily activities currently? *

Would you consider these activities a change from what you used to do? *

Yes No

Do you drive a vehicle? *

Yes No

Please indicate if you are independent or need help with any of the following.

	Do not need help	Need help	Who helps?

Feeding yourself

Getting from bed to a chair

Getting to the toilet

Getting dressed

Bathing

Using the telephone

Taking your medications

Preparing meals

Managing money/financial

Doing laundry

Doing housework

Grocery shopping

Driving

Doing "handyman" tasks

Climbing stairs

Getting to places beyond walking

Do you employ someone to provide care or to help you in your home? *

Yes* No

***If "yes" how many hours a day and how many days a week do you employ someone to provide care in your home?**

Hired in-home care

Hours a day

Days a week

Do you get help from a family member or friend in your home? *

Yes* No

***If "yes" how many hours a day and how many days a week do you get help from a family**

member or friend in your home?

	Help from family or friend in home
Hours a day	
Days a week	

Do you provide care for a family member? *

- Yes
- No

Past Medical History

Please check all medical condition that you have or have had in the past:

Ear and Eye Problems

- Cataracts
- Gloucoma
- Macular degeneration of the eye
- Hearing loss/use of hearing aid

Heart Problems

- Heart attack*
- Heart failure*
- High blood pressure
- Irregular heartbeats (arrhythmia)
- Aortic stenosis

***If you had a heart attack or heart failure, please note what year(s).**

Lung Problems

- Asthma
- Bronchitis
- Emphysema

COPD

Bone and Joint Problems

Arthritis
Osteoporosis
Gout
Fracture*

***Please specify where you have had a fracture (i.e., hip, wrist, spine)**

Gland Problems

Diabetes
Thyroid (overactive/high)
Thyroid (underactive/low)

Kidney and Urinary Tract Problems

Kidney disease
Prostate disease
Frequent bladder or kidney infections
Urinary incontinence

Gastrointestinal Problems

Ulcers
Heartburn/hiatal hernia
Diverticulitis
Liver disease/cirrhosis
Polyps
Gallbladder disease

Nervous system problems

Stoke

Dementia or Alzheimer's disease
Parkinson's disease
Epilepsy or seizures
Exposure to toxins
Head injury*

***If you check head injuries, please specify how many injuries and the dates of each injury.**

Psychiatric Problems

Anxiety
Depression
Bipolar
Psychosis

Other Health Problems

Allergies*
High Cholesterol
Anemia
Hernia
Thrombosis (blood clots) of leg
Thrombosis of lung
Sleep apnea
Cancer
Sexual functioning problems

***Please specify allergies.**

Recent Medical Symptoms

Loss of consciousness or near fainting

Dizziness
Migraines
Change in smell or taste
Hallucinations
Changes in appetite
Loss of urine control or getting wet
Numbness or arm/leg weakness
Problems falling asleep
Problems staying asleep
Tremor or shaking
Problems with falling or loss of balance

List all surgeries (operations) and dates associated with each procedure.

List all hospitalization and dates associated with each admission.

List any neuroimaging (e.g., head CT, MRI of the brain) with dates and ordering physician.

Do you have any drug allergies? *

Yes*

No

***If yes, please state which drugs you are allergic to and the reaction you receive from the drug.**

List all medicines that you use. (prescription, non-prescription, and natural products)

	Name of medication (e.g., Tylenol)	Strength (Dose) (e.g., 500 mg)	How often per day (e.g., 1 pill 3 times a day)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Substance Use History

How often do you drink alcohol, including beer and wine, or other alcohol (e.g., vodka, whiskey, gin)?

Daily

Almost daily

1 to 3 times a week

Less than 1 time a week

Never

If you drink alcohol, has anyone ever been concerned about your drinking?

Yes* No

***If yes, please described who and what was done by that person.**

Have you ever sought treatment due to a drinking problem?

Yes* No

***If yes, please describe treatments you have received and the date of those treatments.**

Have you ever use tobacco?

Yes* No

***If yes, are you smoking now?**

Yes No

***How many years have you smoked?**

***How much tobacco do you use?**

	Yes	No	How often per day?
Cigarettes			
E-cigarettes/Vaping			
Chewing tobacco			

***If you smoked in the past, but are not currently smoking, how many years ago did you quit?**

***How many years did you smoke?**

***How many packs per day did you smoke?**

Have you ever use illicit/recreational drugs?

Yes*

No

***If yes, please specify type(s) of drugs, frequency of use, and if you currently use illicit/ recreational drugs.**

Family History

Have any members of your family members been diagnosed and/or treated for any of the following conditions?

Dementia or Alzheimer's disease

Depression

Anxiety

Other psychiatric problems*

Heart disease

Stroke

Cancer*

Diabetes

***Please specify other psychiatric problems.**

***Please specify which types of cancer.**

Social History

With whom do you live? *

- Alone
- Spouse or partner
- Child or other family members
- Other, not family

Which of the following best describes your residence? *

- Single-family house
- Condo or apartment
- Live with other in their home
- Retirement hotel
- Board and care/residential care facility
- Nursing home

How would you described your current relationship status? *

- Married
- Divorced/separated
- Widowed
- Single/never married

Living with significant other

Did you or your spouse serve in the military?

Yes

No

Do you have children? *

Yes*

No

***If yes, please list the names, ages, and if you have regular contact with each child.**

	Name	Age	Regular Contact	Living With
1				
2				
3				
4				
5				
6				

Education and Work History

How much school did you complete? *

Less than 6th grade
Less than high school graduate
High school graduate
Some college
College graduate
More than college graduate

How many total numbers of formal educational years did you complete? *

Where did you attend school? *

Is English your primary language? *

Yes

No

Specify your primary language and/or other languages you speak.

Did you attend school in the United States

Yes

No*

Educationally, were any subjects more difficult than others? Please specify and describe which ones.

Did you fail any grades? Please describe.

Please describe your current work situation. *

Retired

Working full-time

Working part-time

Unemployed/not working

What is/was your principal occupation and briefly describe your work duties.

Planning for Future Healthcare

Do you have a Durable Power of Attorney (POA)? *

Yes* No

Do you have a living will? *

Yes No

Do you have any additional information that you would like the doctor to know about before your visit?

Emergency Contact

Name of Emergency Contact *

First Name Last Name

Relationship *

Emergency Contact Phone Number *

Phone Number

Area Code