NORTHEAST NEUROPSYCHOLOGY
BRAIN & BEHAVIORAL HEALTH PARTNERS

ADULT FORM

Please call 203-272-6007 if you think you have the wrong form.

ADULT BACKGROUND QUESTIONNAIRE

Confidential Information

In preparation for your Neuropsychological Evaluation, I ask that you complete the following questions. Please answer them completely and in as much detail as possible. I prefer that you complete the questions yourself, but if necessary, you may have a relative or friend assist you. Please use page 11 if additional space is needed to answer any questions. Please bring this completed questionnaire with you to your evaluation.

Patient Name: _____ **Preferred Name** _____

Address: _____

Phone: (home) _____**(work)** _____ **(cell)** _____

Date of Birth: _____ /_____ /_____ **Age:** _____

Current Marital Status: _____ **Lists date(s) of marriage/divorce** _____

Handedness: ❑ **Right** ❑ **Left** ❑ **Ambidextrous** **Education** _____
(Highest Level / Degree)

Birth Sex ❑ **M** ❑ **F** ❑ **Unidentified** **Gender Identity:** _____ **Preferred Pronouns** _____

If another person assisted in completing this form, provide information about him/her:

Name: _____ **Relationship to Patient:** _____

Address: _____ **Phone: (home)** _____

_____ **(work)** _____

_____ **(cell)** _____

If necessary, may this person be contacted for additional collateral information: ❑ **Yes** ❑ **No**

Referral Information: Who referred you for this evaluation? _____

To the best of your knowledge, why do you think you were you referred for this assessment?

_____

What would you like to learn about yourself or accomplish from this evaluation?

_____

MEDICAL HISTORY

Medical Information: Briefly describe what problems or symptoms led you to seek help from your current treatment providers.

_____

_____

_____

Approximately when did these problems/symptoms begin? _____

Have your symptoms: ❑ **Gotten Worse?** ❑ **Gotten Better?** ❑ **Stayed the Same?**

To the best of your knowledge, what is/was the cause(s) of these problems?

_____

_____

_____

What other services do your currently receive? *Please check all your current treatment providers.*

❑ **Physical Therapy** Provider Name _____

❑ **Occupational Therapy** Provider Name _____

❑ **Speech Language Therapy** Provider Name _____

❑ **Cardiology** Provider Name _____

❑ **Psychotherapy** Provider Name _____

❑ **Psychiatry (med management)** Provider Name _____

❑ **Nephrology** Provider Name _____

❑ **Neurology** Provider Name _____

❑ **Other** _____ Provider Name _____

Have you had a neuropsychological evaluation before? ❑ **Yes** ❑ **No**

If Yes **When** _____ Provider Name _____

Reason _____

Medical Hospitalizations: Please list any medical hospitalizations.

Date	Hospital Name/Location	Reason Hospitalized

MEDICAL HISTORY *continued*

Please note if you have any of these conditions/illnesses listed below. Provide details about the conditions/illness on a separate sheet. Also, note if any of your relatives have these conditions as well.

Check if applicable

MEDICAL	SELF	Family Member
Diabetes	❑	❑
Heart Disease	❑	❑
Heart Attack	❑	❑
High Cholesterol	❑	❑
High Blood Pressure/ Hypertension	❑	❑
Cancer (non brain)	❑	❑
Chemotherapy ❑Yes ❑No		
Radiation ❑Yes ❑No		
Lung/Breathing	❑	❑
Asthma	❑	❑
Anemia	❑	❑
Sleep Apnea	❑	❑
Liver Problems	❑	❑
Kidney Problems	❑	❑
Thyroid/Endocrine	❑	❑
Other: _____	❑	❑
Other: _____	❑	❑
NEUROLOGICAL		
Stroke/CVA	❑	❑
Transient Ischemic Attack (TIA)	❑	❑
Seizures/Epilepsy	❑	❑
Multiple Sclerosis	❑	❑
ALS/Lou Gehrig's Disease	❑	❑
Dementia	❑	❑
Alzheimer's Disease	❑	❑
Parkinson's Disease	❑	❑
Huntington's Disease	❑	❑
Dementia w/Lewy Bodies	❑	❑
Frontotemporal Dementia	❑	❑
Arteriovenous Malformation (AVM)	❑	❑
Brain Tumor	❑	❑
Brain Cyst/Growth	❑	❑
Loss of Consciousness/ Syncope	❑	❑
Other: _____	❑	❑
Other: _____	❑	❑

Check if applicable

DEVELOPMENTAL/ LIFE EVENTS	SELF	Family Member
Birth Problems (Premature, Underweight, Jaundice, Rhesus Incompatibility)	❑	❑
Cerebral Palsy	❑	❑
Down Syndrome	❑	❑
Intellectual Disability	❑	❑
Head Injury / Concussion	❑	❑
Severe Allergic Reaction	❑	❑
High Fever (>104 degrees)	❑	❑
Electric Shock	❑	❑
Near Drowning	❑	❑
Toxic Exposure/Poisoning	❑	❑
Other: _____	❑	❑
Other: _____	❑	❑
INFECTIONS		
Meningitis	❑	❑
Encephalitis	❑	❑
HIV/AIDS	❑	❑
COVID 19	❑	❑
Lyme Disease	❑	❑
Mononucleosis	❑	❑
Other: _____	❑	❑
Other: _____	❑	❑

CURRENT SYMPTOMS

Please check all symptoms that apply to you.

PHYSICAL SYMPTOMS

❑ **Difficulty walking**

❑ **Balance Problems**

❑ **Reduced Strength - Where?**

_____

❑ **Tremor/Shakiness**

❑ **Involuntary or Repetitive Movements**

❑ **Reduced Fine Motor Skills**
(using pencil, scissors, keys, handwriting changes)

❑ **Reduced Sense of Touch – Where?**

_____

❑ **Headaches / Migraines**

❑ **Strange Skin Sensations** (Numbness, Tingling, Pins & Needles, Shock-Like, Crawling etc)

❑ **Nausea/Vomiting**

❑ **Hearing Problems** (Loss, Tinnitus, Ringing)

❑ **Sexual Dysfunction**

❑ **Vision Problems** (Double Vision, Blurriness, etc)

❑ **Problems with Sleep**

❑ **Reduced Sense of Smell**

❑ **Significant Weight Loss/Gain in Weight**

❑ **Pain – Where?**

❑ **Lack of Energy / Fatigue**

_____

❑ **Dizziness/Lightheadedness**

❑ **Change in Appetite**

❑ **Continence Problems** (Urinary, Bowel)

Please add any other physical symptoms you are experiencing here.

_____

_____

_____

_____

_____

_____

COGNITIVE SYMPTOMS

Please check all symptoms that apply to you.

Attention and Concentration Difficulties (e.g., losing train of thought, failing to complete tasks without distraction):

❑ Yes ❑ No *(if YES, continue to the next question)*

Approximate Date of onset: _____

Briefly explain difficulties you are having with your attention, or provide examples:

_____

_____

Memory Difficulties (e.g., misplacing objects, upcoming appointments, plans made for the day):

❑ Yes ❑ No *(if YES, continue to the next question)*

Approximate Date of onset: _____

Briefly explain difficulties you are having with your memory, or provide examples:

_____

_____

Processing Speed Difficulties (e.g., slowed thinking, taking longer to complete tasks):

❑ Yes ❑ No *(if YES, continue to the next question)*

Approximate Date of onset: _____

Briefly explain difficulties you are having with your processing speed, or provide examples:

_____

_____

Speech/Language Problems (e.g., misnaming objects, forgetting words, difficulty understanding what is being said, changes in speech volume or clarity):

❑ Yes ❑ No *(if YES, continue to the next question)*

Approximate Date of onset: _____

Briefly explain difficulties you are having with your speech, or provide examples:

_____

_____

Reasoning/Non-Verbal Difficulties (e.g., difficulty with multi-step instructions, difficulty with multi-tasking, difficulty with problem-solving)

❑ Yes ❑ No *(if YES, continue to the next question)*

Approximate Date of onset: _____

Briefly explain difficulties you are having with your reasoning abilities, or provide examples:

_____

_____

EMOTIONAL SYMPTOMS AND BEHAVIORAL DIFFICULTIES: *Check any that apply to you.*

❑ **Depression/Sadness** ❑ **Anxiety/Worry**

❑ **Panic Attacks** ❑ **Phobias/Fears**

❑ **Anger/Irritability** ❑ **Aggressive/Violent Behavior**

❑ **Impulsive/Disinhibited Behavior** ❑ **Unusual Behaviors**

❑ **Bizarre/Strange Experiences** ❑ **Suspicious/Paranoia**

❑ **Hallucinations/Illusions (voices, visions)** ❑ **Thoughts of Harming Self or Another**

Other: _____

_____

DAILY FUNCTIONING

Please note how much assistance you now to complete the following tasks by selecting the appropriate response following each statement.

Please Rate your CURRENT level of independence. *Please check the box for your level of independence.*
(Assistance with any of the below tasks means you need help from family or a Caregiver)

Basic ADLs (dressing, bathing, feeding, walking, transferring out of a chair or bed, etc.)
❑ **I am independent.** ❑ **I need occasional assistance.**
❑ **I need frequent assistance.** ❑ **I need total assistance.**

Complex ADLs (meal planning, grocery shopping, trip planning, etc.)
❑ **I am independent.** ❑ **I need occasional assistance.**
❑ **I need frequent assistance.** ❑ **I need total assistance.**

Money Management (paying bills, balancing checkbook, etc.)
❑ **I am independent.** ❑ **I need occasional assistance.**
❑ **I need frequent assistance.** ❑ **I need total assistance.**
Who does this? ❑ You? ❑ Or Someone else?

Medication Management
❑ **I am independent.** ❑ **I need occasional assistance.**
❑ **I need frequent assistance.** ❑ **I need total assistance.**
Who does this? ❑ You ❑ Or Someone else?

Are you driving? ❑ **YES** ❑ **NO**

If NOT driving, date last drove _____

Stopped because _____

SUBSTANCE USE

Alcoholic beverage serving measurements include:
One SERVING = 5 ounces of wine
One SERVING = 12 ounces of beer
One SERVING = 1.5 ounces of liquor or spirits

ALCOHOL

Do you **currently** drink alcohol? ❑**Yes** ❑**No** If no, did you drink alcohol in the past? ❑**Yes** ❑**No**

How **many servings of alcohol** do you drink? _____/day _____ /week (**on average) * SEE CHART ABOVE**

Preferred drink (including size) _____Size (Ounces) _____

Have you ever consumed alcohol more heavily than you do now?
❑**Yes** ❑**No**

Have you had problems due to your alcohol consumption (e.g., injuries, legal problems, family conflicts, work problems)?
❑**Yes** ❑**No**

Have you ever experienced withdrawal symptoms after stopping use of alcohol (e.g., sweats, shakes, hallucinations, etc)
❑**Yes** ❑**No**

Have you ever had a blackout (i.e., unable to recall a period of time when you had been using alcohol)?
❑**Yes** ❑**No**

Have you ever been involved in alcohol treatment?
❑**Yes** ❑**No**

Is there a history of alcohol abuse in your family?
❑**Yes** ❑**No**

ILLICIT DRUGS

Do you currently use illicit/street drugs? ❑**Yes** ❑**No**
If no, did you use drugs in the past? ❑**Yes** ❑**No**

Check all that you use or have used (include how much, how often):

❑ **Marijuana/Hashish** _____
❑ **Amphetamines (e.g., speed)**_____
❑ **Cocaine/Crack** _____
❑ **Hallucinogens (e.g., LSD, mushrooms, etc**)_____
❑ **Inhalants (e.g., nitrous oxide, glue, etc.)** _____
❑ **Opiates (e.g., heroin, morphine, etc.)** _____
❑ **Designer Drugs (e.g., ecstasy, GHB, etc.)** _____
❑ **Prescription Drugs (e.g., Oxycontin, Xanax, etc.)** _____
❑ **Others (please list)** _____

Have you ever used IV drugs? ❑**Yes** ❑**No**
Have you ever over-dosed on drugs? ❑**Yes** ❑**No**
Any problems related to your drug use (e.g., legal problems, family conflicts, work problems)? ❑**Yes** ❑**No**
Have you ever been involved in drug treatment? ❑**Yes** ❑**No**
Is there a history of drug abuse in your family? ❑**Yes** ❑**No**

SUBSTANCE USE *continued*

NICOTENE

Do you smoke (cigarettes, cigars, pipes)? ❑**Yes** ❑**No**

Do you smoke cigarettes? ❑**Yes** ❑**No**
For how long? _____ Average daily use _____If quit, when? _____
Do you smoke a pipe? ❑Yes ❑No
For how long? _____ Average daily use _____If quit, when? _____
Do you smoke cigars? ❑Yes ❑No
For how long? _____ Average daily use _____If quit, when? _____

Do you use smokeless tobacco (chewing/patches/vape)? ❑**Yes** ❑**No**
Chewing Tobacco ❑Yes ❑No
For how long? _____ Average daily use _____If quit, when? _____
Nicotene Patches ❑Yes ❑No
For how long? _____ Average daily use _____If quit, when? _____
Nicotine Vapes ❑Yes ❑No
For how long? _____ Average daily use _____If quit, when? _____

Caffeine

Do you drink caffeinated beverages? ❑**Yes** ❑**No**
Average daily use _____/day _____/week What type? _____

Over-The-Counter Drugs

Do you regularly use over-the-counter medicines (sleeping pills, pain drugs)? ❑**Yes** ❑**No**
Have you ever used performance-enhancing drugs/substances (e.g. steroids)? ❑**Yes** ❑**No**

MENTAL HEALTH HISTORY

If you are currently working with or have previously worked with a therapist/counselor/psychiatrist or other mental health provider please list below. *If more room is needed please utilize page 11.*

Dates **Provider Name/Location** **Reason Treated**

_____
_____
_____

Have you ever been psychiatrically hospitalized? ❑**Yes** ❑**No** *(if YES, complete the following):*

Dates **Hospital Name/Location** **Reason Hospitalized**

_____
_____
_____

Have you ever been prescribed psychiatric medications? ❑**Yes** ❑**No** *(if YES, complete the following):*

Dates **Drug Name** **Reason Taken**

_____
_____
_____

Have you ever undergone Electroconvulsive Therapy (ECT)? ❑**Yes** ❑**No**

Have any of your family members received treatment for psychiatric problems? ❑**Yes** ❑**No**

PERSONAL INFORMATION

FAMILY

Where were you born? _____

Were there any problems/complications with your birth? ❑**Yes** ❑**No**
(If YES, briefly list)

_____

Difficulties with your early development (e.g., walking, talking, toileting, etc)? ❑**Yes** ❑**No**

Family of Origin:

	Age (or age at death)	Education	Primary Job	Health
Father				
Mother				
Siblings				

Children: Name	**Gender (M/F)**	**Age**	**Health**

List your recreational interests or hobbies you enjoy.
If appropriate, describe how these have been affected by your medical situation.

_____

_____

EDUCATION

Did you graduate from high school? ❑**Yes** ❑**No**
Highest grade completed in grade school _____Year graduated _____

Please check levels of education - Check if Yes

❑**Some college** ❑ **Associate's Degree** ❑ **Bachelor's Degree** ❑ **Master's Degree** ❑ **Doctoral Degree**

List the colleges, technical, and/or vocational schools you have attended (list most recent first):

Name	Years Attended	Primary/Major Area of Study

(continue on page 11, if necessary)

What were your academic strengths in school?

_____

What were your academic weaknesses in school?

_____

Were you ever held back any grades? ❑**Yes** ❑**No** If yes, what grades? _____
Were you ever diagnosed with a learning disability? ❑**Yes** ❑**No**
If you had difficulty in school, describe any special assistance or help you received:

_____

Describe any behavior problems you had in school:

_____

Any plans for education in the future? ❑**Yes** ❑**No**

EMPLOYMENT

Are you currently employed? ❑**Yes** ❑**No** If not, when did you last work? _____

List your work history beginning with your current job and going backwards:
(Be sure to include your occupation, dates of employment and reason for leaving)

_____
_____
_____
_____
_____
_____
_____

(continue on **page 11**, if necessary)

If relevant, describe how your current illness has affected your ability to work: _____
_____

What are your future employment plans? _____

COMPENSATION / LITIGATION

Do you currently receive Social Security Benefits? ❑**Yes** ❑**No**
Do you currently receive Worker's Compensation Benefits? ❑**Yes** ❑**No**
Are you currently receiving any disability compensation as a result of your illness? ❑**Yes** ❑**No**
Are you currently receiving disability compensation for past illnesses? ❑**Yes** ❑**No**
Are you currently involved in a lawsuit or other legal action? ❑**Yes** ❑**No**

Current Attorney: (Be sure to include the current Attorney Name, Location, Phone # & reason.)

_____
_____

Current Medications: Please list all medications you are taking (including over-the-counter drugs).

Medication (name and dose)	**Reason Taking**	**How long?**

Please add any additional information here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date Completed

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