Transitions Professional Center, LLC

Psychologists Specializing in Health, Rehabilitation, Palliative Care & Bereavement

Neuropsychological and Health Screening Questionnaire

Name: _____ Date of birth: _____Today's date: _____

Address: _____

Phone #: _____ Alternate phone #: _____

Age: _____ Gender: M / F Ethnicity: _____

Family contact - Name: _____ Relationship to patient: _____

Phone #: _____ Address: _____

Primary care physician - Name: _____ Location: _____

Neurologist - Name: _____ Location: _____

Place of birth: _____ Is English your native language? Y / N

Other languages spoken: _____

Developmental History

To the best of your knowledge…

Any difficulties with your mother's pregnancy or delivery with you? Y / N

If yes, please describe: _____

Any delays in sitting up, walking, talking or toilet training? _____

Did your mother use any of the following during her pregnancy with you?

Alcohol:	Y / N
Illegal drugs:	Y / N
Prescription drugs:	Y / N

During childhood, did you have…?

Any unusual injuries: Y / N

Any unusual illnesses: Y / N

Hospitalizations: Y / N

Other medical problems: Y / N

Specify: _____

_____

Did you experience problems with any of the following during childhood/adolescence?

Hearing:	Y / N	Speaking:	Y / N
Stuttering:	Y / N	Reading:	Y / N
Writing:	Y / N	Spelling:	Y / N
Arithmetic:	Y / N	Strength/Coordination:	Y / N
Hyperactivity:	Y / N	Behavior/Conduct:	Y / N
Attention deficit:	Y / N	Learning disability:	Y / N

Educational History

Did you earn your high school diploma or a GED? (please circle one)

HS Diploma GED No HS Diploma or GED

Highest Degree Earned: _____

Were your average grades…? (please circle one)

Poor(D's/F's) Fair (C's) Excellent (B's/A's)

Did you utilize accommodations or special education in school? Y / N

Please list colleges attended, grades/GPA, major(s): _____

_____

Occupational History

Are you currently working? Y / N If not, when did you last work? _____

Current or primary lifetime occupation? _____ How long?_____

Psychiatric History

Do you have a history of depression? Y / N

Do you have a history of anxiety? Y / N

Do you have a history of other psychiatric diagnoses? Y / N

If yes, please explain_____

Have you ever attempted suicide? Y / N

Have you ever had any psychiatric hospitalizations? Y / N

Have you ever received outpatient psychotherapy? Y / N

Have you ever taken medications for a mental health condition? Y / N

How much alcohol do you currently consume? _____drinks per week

List any recreational drugs currently used _____

Is there a history of alcohol or substance abuse in the past? Y / N

Have you ever smoked? Y / N Current? Y / N Quit Date? _____

How many packs per day do you/did you smoke? _____

Do you have a legal history, civil or criminal? If so, please explain here: _____

_____

_____

Please fill out the enclosed medication form, listing all medications (including over-the-counter medications, vitamins and herbs) that you are currently taking.

Medical History

	Have you experienced…? *(include date of diagnosis or event)*	*Do you have a family history of…?*
Hospitalizations/surgery:	Y / N _____ date	Y / N _____ relation
Stroke or "mini-stroke":	Y / N _____ date	Y / N _____ relation
Head trauma or concussion:	Y / N _____ date	Y / N _____ relation
Vascular/circulatory problems:	Y / N _____ date	Y / N _____ relation
Endocrine (inc. Diabetes)/thyroid:	Y / N _____ date	Y / N _____ relation
Respiratory problems:	Y / N _____ date	Y / N _____ relation
Cardiac problems:	Y / N _____ date	Y / N _____ relation
High blood pressure:	Y / N _____ date	Y / N _____ relation
High cholesterol:	Y / N _____ date	Y / N _____ relation
Frequent headaches:	Y / N _____ date	Y / N _____ relation
Toxic exposure:	Y / N _____ date	Y / N _____ relation
Kidney/liver problems:	Y / N _____ date	Y / N _____ relation
Seizure disorder:	Y / N _____ date	Y / N _____ relation
Alzheimer's disease:	Y / N _____ date	Y / N _____ relation
Parkinson's disease:	Y / N _____ date	Y / N _____ relation
Multiple Sclerosis:	Y / N _____ date	Y / N _____ relation

Other: _____

Are you allergic to any medications? Please list: _____

_____

Family History

How many siblings do you have? _____Any health conditions?_____

If any siblings are deceased, please provide age(s) at death and reason: _____

If father is deceased, please provide age at death and reason: _____

If mother is deceased, please provide age at death and reason: _____

How many children have you had (living or deceased)? _____

Previous Tests

Have you ever had brain imaging (CT, MRI, PET, SPECT)? Y / N

If yes, where and when? _____

What were the findings? _____

Have you ever had neuropsychological testing before? Y / N

If yes, where and when? _____

***If yes, we ask that you bring a copy of that report with you to the appointment or have it faxed to us prior to the appt. Our fax number is 503-972-7093.**

Current Symptoms

Please describe your main **cognitive** symptoms: _____

_____

Do you have problems remembering things? Y / N

If yes, what types of things? _____

Do you have difficulty finding the right word to use? Y / N

Do you have difficulty understanding what others say? Y / N

Do you have trouble focusing? Y / N

Are you easily distracted? Y / N

Do you have trouble multi-tasking? Y / N

Do you have difficulty making decisions? Y / N

Do you have difficulty processing visual information? Y / N

Please describe your main **physical** symptoms: _____

_____

Do you have difficulty with big movements like getting up from a chair or walking? Y / N

Do you have difficulty with small movements like fastening buttons or handwriting? Y / N

Do you have abnormal movements you cannot control? Y / N

Do you have problems with your posture or balance? Y / N

Do you have difficulty chewing or swallowing? Y / N

Do you have ringing in your ears? Y / N

Do you have weakness? Y / N

Do you have swelling of the ankles/legs? Y / N

Do you have purplish discoloration of hands/feet? Y / N

Do you have any incontinence (wetting or soiling yourself)? Y / N

How many hours of sleep do you usually get per day? _____ Are you tired/fatigued during the day? Y / N

Please describe your main **emotional** symptoms: _____

_____

Are you currently depressed? Y / N

Are you currently anxious? Y / N

Are you currently suicidal? Y / N

Have you noticed personality changes? Y / N

Are you more impulsive than usual? Y / N

Are you more irritable than usual? Y / N

Are you easily overwhelmed? Y / N

With respect for your overall symptoms, when did they begin? (e.g., gradually, suddenly, intermittently):

_____

_____

Have things progressed? Y / N If yes, how? _____

_____

_____

What treatments have you tried? _____

_____

_____

Has anything helped or worsened the symptoms? _____

_____

_____

Living Situation and Activities of Living

With whom do you live? _____

Is anyone available to help out if needed? Y / N If yes, who? _____

Are there significant financial problems or other daily stressors? Y / N If yes, please explain: _____

_____

_____

Do you require assistance with any of the following?

Eating?	Y / N	Grooming?	Y / N
Bathing?	Y / N	Toileting?	Y / N
Dressing?	Y / N	Walking?	Y / N
Laundry	Y / N	Managing your finances?	Y / N

Using the phone? Y / N Managing your medications? Y / N

Shopping? Y / N Maintaining your home? Y / N

Preparing food? Y / N

Do you drive? Y / N Any difficulties driving? Y / N

Do you have difficulty with any other mode of transportation? Y / N

Do you have a Durable Power of Attorney for Health Care? Y / N

Do you have a Durable Power of Attorney for Finances? Y / N

Do you have a Health Care Advanced Directive? Y / N

Have you completed a POLST? Y / N

Is the current evaluation part of a legal case? Y / N

Do you have currently have a lawyer? Y / N