ACAPS
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Patient Questionnaire & History

Adult Form

Please print clearly & complete as thoroughly as possible.

Today's Date: _____

Name of person completing this form: _____

If other than the patient, please list relationship to patient: _____

Patient Demographics

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name:_____Date of birth: _____

Biological Sex: Male / Female Gender Identity: Male / Female / Other:_____

Street/Mailing Address: _____

City: _____ State: _____Zip/Postal Code: _____

Home Phone #: _____ Cell Phone #: _____

The patient is: Right Handed / Left Handed / Ambidextrous (uses both hands equally)

Has preferred handedness ever changed? Yes / No If yes, when did this occur? _____

Is English your first language? Yes / No If not, what is your first/primary language? _____

Have you ever had neuropsychological or psychological testing before? Yes / No

If yes, by whom? _____ When? _____

(Please provide a copy of this report, if possible)

Referral Source Information

Who referred you to ACAPS for this evaluation? _____

Street Address: _____

City:_____ State:_____Zip/Postal Code: _____

Phone #:_____ Fax #: _____

Medical diagnosis (if applicable): _____

History of Presenting Problem

Why are you being seen for a neuropsychological/psychological evaluation (e.g. stroke, head injury, emotional concerns, memory problems, etc.)?

_____

_____

Date problem(s) began (estimate, if unsure): _____

Course: _____ Getting Better _____ Getting Worse _____ Staying the Same

How have overall symptoms developed? _____Slowly _____Quickly _____Not sure

Is there anything that seems to make the problem(s) less frequent/less intense? Yes / No

If so, please explain: _____

Is there anything that seems to make the problem(s) worse? Yes / No

If so, please explain: _____

Symptom Survey

(Please check all that apply to you within each category)

Physical

Please indicate if you are experiencing any of the following currently:

____headaches

____dizziness

____nausea

____vomiting

____urinary incontinence

____loss of bowel control

____blackout spells (fainting)

____excessive tiredness

____pain (if so, please indicate location(s)):

_____

____balance difficulties

____walking more slowly than other people

____weakness on one side of the body

If so, please indicate side: Left (L) / Right (R)

____writing is very small

____writing is very large

____tremors or shakiness

____difficulty holding onto things

____other physical problem(s) (if so, please list):

_____

Attention/Concentration

Which of the following describe(s) you currently? :

____highly distractible
____make careless errors
____have problems with concentrating/paying attention
____mind appears to go blank at times
____have difficulty following instructions
____tend not to be very alert or aware of things
____lose train of thought more often than typical or expected
____experience difficulty writing letters/words, (not related to motor skills)
____have slow reaction time

Problem Solving

Please indicate if you currently experience any of the following:

____difficulty figuring out how to do new things
____difficulty with organizing and planning
____think/feel that most people talk too fast
____difficulty switching from one activity to another
____difficulty doing things in the right order (sequencing)
____ difficulty completing an activity in a reasonable amount of time

Sensory

Please indicate if you currently experience any of the following:

____difficulty hearing (please indicate: L / R)
____ringing in ears (please indicate: L / R)
____hearing strange sounds
____difficulty tasting food
____difficulty smelling
____smelling strange odors
____loss of feeling or numbness
____tingling or strange skin sensations
____difficulty distinguishing hot from cold
____problems seeing on one side (please indicate: L / R)
____blurred vision
____blank spots in vision
____brief periods of blindness
____seeing “stars” or flashes of light
____double vision
____difficulty looking quickly from one object to another

Speech, Language, and Math Skills

Please indicate if you currently experience any of the following:

____difficulty finding the right word(s) to say
____slurred speech
____difficulty understanding what others are saying
____difficulty expressing thoughts/explaining
____difficulty staying with one idea during a conversation
____produce odd or unusual speech sounds
____difficulty understanding what is read
____difficulty spelling
____difficulty with math (e.g. checkbook balancing, making change, etc.)
____use of incorrect words
____other speech, language, and/or academic problems:_____

Nonverbal Skills

Please indicate if you currently experience any of the following:

____difficulty telling Left from Right
____difficulty drawing or copying
____difficulty doing things that should be "automatic" (e.g. brush teeth)
____difficulty writing letters (not due to motor problems)
____difficulty finding your way around *familiar* places
____difficulty recognizing objects or people
____difficulty with puzzles, Legos, blocks, or similar games
____unaware of things on one side of body (please indicate: Left / Right)
____get lost easily
____difficulty recognizing facial expressions (emotions)
____not aware of time (day, season, year)
____other:_____

Memory

Please indicate if you currently experience any of the following:

____forget where you leave things (e.g. keys, purse, phone, etc.)
____forget names
____forget what you should be doing
____forget where you are or where you are going
____forget recent events (e.g. last meal, recent doctor's visit)
____forget events that happened long ago (months or years)
____forget appointments
____forget facts, but can remember how to perform tasks
____forget the order of events
____repeat yourself often

____leave stove on, freezer open
____have difficulty remembering newly learned material
____need someone to give you a 'hint' so you can remember things
____forget the order of things (e.g. when cooking, getting ready)
____forget faces of people you know (when they are not present)
____more reliant on notes to remember things

Behavioral and Emotional

Please indicate if you currently experience any of the following:

____sadness / depression
____anxiety / nervousness
____weight loss
____overeating
____stress
____sleeping problems:
(falling asleep___ staying asleep ___)
____recurrent / intrusive thoughts
____anger, more so than in the past
____euphoria (e.g. feeling on top of the world)
____increased emotionality (e.g. cry more easily)
____apathy, feel as if you just don't care anymore
____decreased inhibition (e.g. doing things that you would not risk doing previously)
____loss of interest in almost all activities
____feelings of worthlessness
____feelings of hopelessness
____poor self-esteem
____sexual problems
____impatience, difficulty waiting your turn
____change in energy levels
(indicate: Decrease / Increase)
____change in appetite
(indicate: Decrease / Increase)
____very fidgety
____resistant to change
____thoughts of harming self or others
____nightmares
____racing thoughts
____hear voices or see things that others do not hear or see
____exhibit sexually inappropriate behaviors
____rarely follow others' instructions
____ other: _____

Daily Living

Please indicate if you currently experience any of the following (not due to physical inability):

____difficulty dressing
____difficulty bathing/showering
____recent falls
____require assistance for toileting
____difficulty with grooming
____difficulty with eating /feeding self
____difficulties with telling time
____difficulty preparing a list and shopping independently
____problems managing household/personal finances
____unable to drive safely

Recent Stressors

Please indicate if you currently experience or recently experienced any of the following:

____change in job (or loss of job)
____death of loved one
____moved to new location
____change in marital status
____financial or legal problem(s)
____taking care of aging loved one(s)
____other: _____

Patient History

Medical History

Primary care doctor:_____Office name:_____

Office #: _____ Fax #:_____

Please indicate if you have received any of the following:

___CT Scan, if yes, date: _____
___fMRI, if yes, date: _____
___MRI, if yes, date: _____
___SPECT, if yes, date: _____
___PET, if yes, date: _____
___EEG, if yes, date: _____
___EKG, if yes, date: _____
___MEG, if yes, date: _____
___Spinal tap, if yes, date: _____

Please check all the conditions that you have been diagnosed with in the past:

___Adrenal gland disorder

___AIDS/HIV positive

___Alzheimer's

___Amputations

___Arteriosclerosis

___Arthritis

___Asthma

___Blood disease (e.g. anemia)

___Bowel or bladder incontinence

___Brain aneurysm

___Brain/Spinal disorder

___Brain tumor

___Broken bones/fractures

___Bronchitis

___Cancer:

___Chronic ear infections

___Chronic fatigue syndrome

___Colon disease (e.g. Chohn's, IBS)

___Concussion/head injury

___Cushing's syndrome

___Degenerative joint disease

___Diabetes

___Dizziness (e.g. vertigo)

___Encephalitis

___Endocrine problems

___Epilepsy/seizures

___Fibromyalgia

___Gastroesophageal reflux disease (GERD)

___Heart disease

___High blood pressure

__ High cholesterol

___High cholesterol

___Hydrocephalus

___Hyperthyroidism

___Hypoglycemia

___Hypothyroidism

___Irritable bowel syndrome

___Kidney disease

___Kidney disorder

___Liver disease

___Low testosterone

___Lung disease

___Lupus

___Macular degeneration

___Meningitis

___Migraines

___Mood disorder

___Movement disorder

___Multiple sclerosis

___Pancreatitis

___Parathyroid disorder

___Parkinson's Disease

___Polio

___Regular urinary tract infection

___Senility/Dementia

___Stroke

___Swallowing disorder

___Thyroid disease

___Traumatic brain injury

___Tumor: _____

___Ulcer

___Other:_____

Learning History

Rate your developmental progress, as it has been reported to you, by checking **one** description for each area:

	Early	Average	Late
Walking:	_____	_____	_____
Language development:	_____	_____	_____
Toilet training:	_____	_____	_____
Overall development:	_____	_____	_____

Please indicate if you have experienced any of the following, either **as a child** or **prior to your injury:**

____learning problems
____school problems
____attention/ concentration problems
____hyperactivity
____alcoholism
____drug abuse
____psychiatric hospitalization(s)
____moodiness, irritability
____speech-language issues
____anxiety
____obsessive compulsive tendencies/behaviors
____depression
____suicidal ideation
____vision problems
____involvement with police or juvenile authorities
____difficulties socializing with others
____other:_____

Medication History

List the medications that were regularly given to you **as a child** (if applicable):

Medication: Reason for Medication:

1._____
2._____
3._____
4._____

List any **current** medications you are taking (over the counter or prescription medication) and dosage:

Medication: Dosage: Reason for Medication:

1._____
2._____
3._____

4._____

List any medications you are allergic or sensitive to: _____

Have you ever been placed on disability? Yes / No

If yes, please explain: _____

Describe all of the hospitalizations you have had:

1._____

2._____

3._____

4._____

Family History

Mother's Name: _____

Is she alive? Yes / No If deceased, known cause of death? _____

Mother's Occupation: _____ Highest level of education completed: _____

Your mother's age at your birth: _____ Did your mother raise you? Yes / No

Does your mother have a known or suspected learning disability or psychological disorder? Yes / No

If yes, please explain: _____

Briefly describe your mother's health history: _____

_____

Father's Name: _____

Is he alive? Yes / No If deceased, known cause of death? _____

Father's Occupation: _____ Highest level of education completed: _____

Your father's age at your birth: _____ Did your father raise you? Yes / No

Does your father have a known or suspected learning disability or psychological disorder? Yes / No

If yes, please explain: _____

Briefly describe your father's health history: _____

_____

If raised by someone other than your mother or father, please explain: _____

_____

For the items below, please indicate diagnoses/issues experienced by biological (blood-related) family members (e.g. parents, siblings, and grandparents) **and** specify which family member experienced diagnosis/issues(s):

Diagnosis, problems, etc.:	Family member(s):
_____Epilepsy/seizures	_____
_____Learning disability	_____
_____ Neurological (Parkinson's, Alzheimer's, M.S. etc.)	_____
_____Developmental (Autism, ADHD, Dyslexia, etc.)	_____
_____Psychiatric (Depression, Anxiety, Bipolar, etc.)	_____
_____Alcoholism	_____
_____Speech-Language disorder	_____
_____Other: _____	_____

Personal History

Current marital status: _____married _____in a relationship _____single
_____divorced _____widowed _____separated

If married:

Spouse's name: _____ Spouse's age: _____

Spouse's occupation: _____ Spouse's education: _____

Spouse's health: _____Excellent _____Good _____Poor _____Other

If problems/concerns exist, please explain:

_____

If not married, are you living with someone: _____Yes _____No If yes, his/her age: _____

His/her occupation: _____ His/her education: _____

His/her health: _____Excellent _____Good _____Poor _____Other

If problems, please explain: _____

Do you have any children? _____ Yes _____No If yes, how many children, and his/her/their age(s):

_____

_____

Main source of income: _____

Educational History

Highest grade completed/degree earned: _____

How would you describe your usual performance as a student in: (please circle highest level):

High school	Excellent	Good	Average	Poor
College	Excellent	Good	Average	Poor

What was/were your best/strongest subject(s)? _____

What was/were your weakest subject(s)? _____

Did you require special education? ____Yes _____No If yes, what type of special education?_____

What grade/age did you receive special education services? _____

Occupational History

Current job title: _____

Length of employment: _____ Hours worked per week: _____

Current job responsibilities: _____

_____

Prior jobs (start with most recent) – at least the past 10 years

Job/Position: Reason for leaving:

1. _____
2. _____
3. _____
4. _____

At any time on a job, were you exposed to toxic, hazardous, noxious or otherwise dangerous or unusual substances (e.g. lead, mercury, radiation, solvents, pesticides, chemicals, etc.)? _____Yes _____No

Have you ever been terminated from a job? _____Yes ____No If yes, please explain: _____

_____

Military History

Branch: _____

Discharge rank: _____ Type of discharge: _____

Major military duties: _____

Did you sustain any physical injuries in the military? _____ Yes _____ No If yes, please explain: _____

_____

Were you exposed to any dangerous or unusual substances during your service (e.g. Agent Orange, radiation, etc.)? _____Yes _____ No If so, please explain: _____

Social History

Briefly list the types of recreational activities (sports, games, TV, hobbies, etc.) you engaged in prior to your injury/illness: _____

_____

Which of the above recreational activities do you continue to engage in? _____

_____

Briefly list typical social activities you engaged in (church, clubs, service organizations, etc.) before your injury/illness: _____

_____

Which of the above social activities do you continue to engage in? _____

_____

Substance Use History

At what age did you begin consuming alcohol regularly? (choose all that apply):

_____less than 10 years old _____10-15 years old _____16-18 years old

_____19-21 years old _____over 21 years old _____I do not drink alcohol

_____I used to drink but have stopped

Frequency that you consume alcohol (currently):

____ rarely/never _____1-2 days/week _____3-5 days/week _____daily

Please check all the substances/drugs you are now using and ones you have used in the past:

	Presently using	Used in the past
_____Amphetamines (including diet pills)	_____	_____
_____Barbiturates (downers, etc.)	_____	_____
_____Cocaine or crack	_____	_____
_____Hallucinogens (LSD, acid, STP, etc.)	_____	_____
_____Inhalants (glue, nitrous oxide, etc.)	_____	_____
_____Marijuana	_____	_____
_____Opiate narcotics (heroin, morphine, etc.)	_____	_____
_____PCP (or angel dust)	_____	_____
_____Other:	_____	_____

Do you consider yourself (currently) dependent on any of the substances listed above? ____ Yes ____ No

If yes, please list which one(s): _____

Do you consider yourself dependent on any prescription drugs? _____ Yes _____ No

If yes, please list which one(s): _____

Check all that apply:

_____I have gone through drug withdrawal _____I have used I.V. drugs

_____I have been in drug treatment

Legal History

Have you ever been arrested for, or convicted of, any offense? _____ Yes _____ No

If yes, please explain: _____

_____

Are you currently involved in a lawsuit/litigation? _____ Yes _____ No

If yes, please explain: _____

_____

Attorney's Name: _____

Have you ever filed for Workers Compensation? _____ Yes _____ No

If yes, please explain: _____

Please list any juvenile legal problems (theft, truancy, etc.) _____

_____

Please list any previous legal problems (DUI, assault, personal injury, civil, etc.) _____

_____

Notes to our Team

Please feel free to share any additional information that we have not covered in this form. Please feel free to list questions and concerns if you have any:

_____

_____