ACAPS
Appalachian Counseling and Psychological Services, Inc.

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ACAPS Adult Patient Questionnaire & History

Please take the time to complete this questionnaire completely. This questionnaire helps the testing team with developing your testing plan. Additionally, your history is useful to our understanding you and interpreting your test results. Missing information and/or inaccurate information may lead to inaccurate conclusions and/or recommendations that are not useful to you. Please print clearly.

Today's date: _____

Name of person completing this form: _____

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

Patient Demographics

Name: _____
Last First (Preferred) Middle Initial

Birth Date: _____/_____/_____ Age:_____

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

Current Address: _____
(Street) (City) (State) (Zip Code)

Home Phone: _____ May we leave a message? Yes No
Cell/Other: _____ May we leave a message? Yes No
Work Phone: _____ May we leave a message? Yes No
Email: _____ May we email you?* Yes No

Who may we contact in case of an emergency? _____ Telephone: _____

Referral Source Information

Referred by: _____

Street Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Phone #: _____ Fax: _____

History of Presenting Problem

Briefly describe why you want to be seen for a neuropsychological/psychological evaluation (e.g., stroke, head injury, emotional concerns, memory problems, etc.)?

_____

_____

_____

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

_____

Course of problem(s):	Getting Better	Getting Worse	Staying the Same
Overall symptoms have developed:	Slowly	Quickly	Not sure

Is there anything that seems to make the problems less frequent/less intense? Yes No

If so, please explain: _____

Is there anything that seems to make the problems worse? Yes No

If so, please explain: _____

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

If yes, by whom? _____When? _____

What do you hope to gain from this evaluation?

_____

_____

Medical History

Please provide the name, address, and telephone number for your primary care physician: _____
_____
_____

Please list other medical professionals you have seen in the past two years, e.g., neurologist, cardiologist, etc.

_____
_____

How is your physical health at the present time? Poor Unsatisfactory Satisfactory Good Very good

Please indicate the date, location, and results (if known) of any of the following procedures.

Procedure	**Date**	**Location**	**Results**
CT Scan			
fMRI			
MRI			
SPECT			
PET			
EEG			
EKG			
MEG			
Spinal Tap			
Other/additional			
Other/additional			

If applicable, please indicate *at what age* you were diagnosed with any of the following:

_____ 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
_____ Diabetes
_____ Dizziness (e.g., vertigo)
_____ Encephalitis
_____ Endocrine problems
_____ Epilepsy/seizures
_____ Fibromyalgia
_____ Gastroesophageal reflux disease (GERD)
_____ Heart disease
_____ High blood pressure
_____ High cholesterol
_____ Macular degeneration
_____ Meningitis
_____ Migraines
_____ Movement disorder
_____ Multiple sclerosis
_____ Pancreatitis
_____ Parathyroid disorder
_____ Parkinson's Disease
_____ Polio
_____ Regular urinary tract infection
____ Senility/Dementia

_____ Brain tumor
____ Broken bones/fractures
____ Bronchitis
____ Cancer: _____
____ Chronic ear infections
____ Chronic fatigue syndrome
_____ Colon disease (Chron's, IBS)
_____ Concussion/head injury
_____ COVID-19
_____ Cushing's syndrome
_____ Down's syndrome
_____ Fetal Alcohol Syndrome
_____ Hydrocephalus
_____ Hyperthyroidism
_____ Hypoglycemia
_____ Hypothyroidism
_____ Irritable bowel syndrome
_____ Kidney disease
_____ Kidney disorder
_____ Liver disease
_____ Low testosterone
_____ Lung disease
____ Stroke
____ Swallowing disorder
____ Thyroid disease
____ Traumatic brain injury
____ Tumor: _____
____ Ulcer
____ Lyme's Disease
____ Other: _____

Please circle any issues below that apply to you:

Balance difficulties
Blackout spells/fainting
Difficulty holding onto things
Dizziness
Eating difficulties
Excessive tiredness
Frequent falls
Hallucinations
Loss of bowel control
Memory lapse
Nausea
Pain (Location): _____
Panic attacks
Tremors or shakiness
Walking more slowly than other people your age
Weakness on one side of the body (if so, please indicate side): Left (L) / Right (R)
Other physical problem(s) (if so, please list): _____
_____

Medications

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

Medication: Reason for Medication:

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

List all **current** over-the-counter and/or prescription medication and/or supplements you take regularly (you can provide a medication list on a separate piece of paper if you wish):

Name: Dosage: Reason:

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: _____

List all the hospitalizations you have had:

	Name of hospital:	Date and Duration:	Reason:
1.			
2.			
3.			
4.			

Sleep

On average, how many hours of sleep do you get per night? _____

Are bed/sleep and wake times consistent throughout the week? Yes No

Consistent on the weekend? Yes No

What time do you *go to bed?* _____ *fall asleep?* _____ *wake up?* _____

Please circle any of the following that apply to you:

Difficulty falling asleep	Difficulty staying asleep	Sleep walking
Difficulty waking up	Frequent nightmares	Sleep apnea
Restless legs		

Have you had a sleep study? Yes No

If yes, please reason (if applicable): _____

Do you have a CPAP machine? Yes No

Do you consume alcohol or other substances to help you sleep? Yes No

Do you use medications to help you sleep? Yes No

Eating/Appetite

Please circle any of the following that apply to you:

Recent loss of appetite	recent increase in appetite	over-eating
History of eating disorder	recent weight loss	recent weight gain

Are you currently on a prescribed diet (e.g., using supplemental nutrition, physician monitored weight loss program, etc.)? Yes No

If yes, please explain: _____

How many meals do you eat each day? _____ How much water do you drink each day? _____

Birth History

Please list any illness or complications your mother experienced while pregnant (e.g., pre-eclampsia, excessive vomiting, toxemia, pre-term labor, etc.).

_____

Please list any complications that occurred during labor/delivery (e.g., lengthy labor, breech presentation, cord around neck, etc.).

_____

Please circle which, if any, of the following occurred:

Use of forceps Use of vacuum extraction

Planned Caesarean Section Emergency Caesarean Section

Were you carried full term? Yes No

What was your birth weight? _____

Did you spend any time in the NICU? Yes No

If yes, why, and how long? _____

Sensory/Motor History

You are: Right-Handed / Left-Handed / Ambidextrous (use both hands equally)

Has preferred handedness ever changed? Yes No

If yes, when did this occur? _____

Have you ever been *evaluated* by an occupational or physical therapist? Yes No

If so, when did the evaluation occur? _____

Who completed the assessment? _____

Who provided these services? _____

Have you been provided occupational or physical therapy? Yes No

If so, when did therapy occur? _____

Please explain why you needed these services e.g., injury, delays in development, to recover from injury/illness, etc. _____

Please circle which, if any, you *currently* experience.

Difficulty hearing (please indicate: L / R) Ringing in the ear (please indicate: L / R)

Hearing strange sounds Difficulty tasting food Difficulty smelling

Loss of feeling or numbness Blurred visions Tingling or strange skin sensations

Blank spots in vision Double vision Difficulty distinguishing hot from cold

Problems seeing on one side (please indicate: L / R) Brief periods of blindness

Seeing "stars" or flashes of light Difficulty looking quickly from one object to another

Do you wear glasses/contacts? Yes No

Do you wear hearing aids? Yes No

Please circle if you *currently* experience difficulties with:

Telling left from right Doing puzzles, Legos, blocks or similar games

Getting lost easily Doing things that should be "automatic" (e.g. brush teeth)

Recognizing objects or people Recognizing facial expressions (emotions)

Drawing or copying Writing letters (not due to motor problems)

Finding your way around *familiar* places Not being aware of time (day, season, year)

Other: _____

Are you unaware of things on one side of your body? If so, please indicate: Left / Right

Speech/Language History

Is English your first/primary language? Yes No

If not, what is your first/primary language? _____

Have you ever been evaluated by a speech-language therapist? Yes No

If so, when did the evaluation occur? _____

Who completed the assessment? _____

Have you ever been provided speech-language therapy? Yes No

If so, when? _____

Who provided the therapy? _____

What was the diagnosis? _____

Please circle if you are *currently* having problems with any of the following:

Articulation Stuttering Describing things and people

Understanding what is being said Re-telling stories/experiences in the proper sequence

Getting "tongue-tied" saying a word you didn't mean to say

Finding the word you want to say

Learning/Academic History

Highest grade completed/degree earned: _____ What school: _____

How would you describe your usual performance as a student in:

High School:	Excellent	Good	Average	Poor
College:	Excellent	Good	Average	Poor

Did you ever repeat a grade? Yes No

If yes, which one? _____

Were you ever diagnosed as having a learning disorder/disability? Yes No

If yes, what area(s)? Reading Math Writing

Please circle any of the following you have received *at school*:

Individualized Education Plan (IEP)	504 Plan	Special Education Classes
Enrollment in TIER programs	RtI Services	Tutoring
Occupational or speech/language therapy	IQ Testing	AIG/Gifted

Did you ever have tutoring outside of school? Yes No

Have you ever had intelligence/IQ testing? Yes No

Occupational/Vocational History

Current job title: _____

Length of employment: _____Hours worked per week: _____

How long have you been at this job? _____

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: _____

Substance Use History

At what age did you begin consuming alcohol regularly (more than once a month)?

_____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

Frequency that you currently consume alcohol:

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) depending 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): _____

Have you gone through drug withdrawal? Yes No

Have you used I.V. drugs? Yes No

Have you participated in treatment for alcohol dependence/drug use? Yes No

If yes, when and where? _____

Please circle any of the following problems you may have experienced due to drinking or drug use:

loss of relationship(s) loss of job school problems illness/health problems

legal problems loss of housing Other: _____

Emotional/Behavioral Health

Have you ever participated in counseling/therapy? Yes No

If yes, when? _____

Name of psychotherapist/counselor(s) and agency/practice(s): _____

_____

Please indicate at what age you have **ever** been diagnosed with any of the following conditions, if so at what age:

_____ ADHD or ADD
_____ Adjustment Disorder
_____ Anxiety
_____ Autism Spectrum/Asperger's Syndrome
_____ Bipolar Disorder
_____ Conduct Disorder
_____ Depression
_____ Dissociative/Depersonalization Disorder
_____ Oppositional Defiant Disorder
_____ Obsessive-Compulsive Disorder
_____ Post-Traumatic Stress Disorder
_____ Personality Disorder
_____ Tics
_____ Tourette's
_____ Other emotional/behavioral issues not listed (please explain): _____

_____

Please circle if you *currently* experience any of the following:

Anger, more so than in the past
Impatience, difficulty waiting your turn
Apathy, feel as if you just don't care anymore
Increased emotionality (e.g., cry more easily)
Anxiety/nervousness
Loss of interest in almost all activities
Decrease in energy level
Poor self-esteem
Decreased inhibition (e.g., doing things that you would not risk doing previously)
Racing thoughts
Recurrent/intrusive thoughts
Euphoria (e.g., feeling on top of the world)
Resistant to change
Feelings of hopelessness
Sadness
Feelings of worthlessness
Sexually inappropriate behaviors
Hear voices or see things that others do not hear or see
Sexual problems
Hyperactivity
Stress
Other: _____

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 (e.g., theft, truancy, etc.). _____

_____

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

_____

Family History

Were you adopted? Yes No

If yes, please indicate at what age and provide details regarding circumstances (if you can): _____

_____

Please check all items that apply to your biological parents:

Biological Mother:
___Alcoholism
___Anxiety
___Attention/Concentration problems
___Depression
___Drug abuse
___Hyperactivity
___Learning problems
___Moodiness
___Obsessive Compulsive Disorder
___Psychiatric hospitalization
___School problems
___Speech-Language Disorders
___Suicide
___Unreasonable fears (phobias)

Biological Father:
___Alcoholism
___Anxiety
___Attention/Concentration problems
___Depression
___Drug abuse
___Hyperactivity
___Learning problems
___Moodiness
___Obsessive Compulsive Disorder
___Psychiatric hospitalization
___School problems
___Speech-Language Disorders
___Suicide
___Unreasonable fears (phobias)

For the items below, please indicate diagnoses/issues experienced by other ***biological*** (blood-related) family members (e.g., siblings, grandparents, etc.) **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: _____	_____

If you were not raised by both of your biological (or adoptive) parents, with whom did you live as a child, e.g., grandparents, mother and step-father, etc.? _____

_____

Relationship History

I am currently (circle one): married/partnered in a relationship with single
divorced widowed separated

If married/partnered:

Spouse/Partner's name: _____ Age: _____

Occupation: _____ Education: _____

Spouse/Partner's health: Excellent Good Poor Other

If problems/concerns exist, please explain: _____

_____

Do you have any children? Yes No

If yes, please provide name(s) and age(s): _____

_____

_____

Social/Recreational History

Briefly list the types of recreational activities (sports, games, TV, hobbies, etc.) you have enjoyed/engaged in:

_____

_____

Which of the above recreational activities are you no longer able to do and why? _____

_____

Briefly list typical social activities you have enjoyed/engaged in (church, clubs, service organizations, etc.):

_____

_____

Which of the above social activities are you no longer able to do and why? _____

_____

Attention, Concentration, Problem Solving & Memory

Please indicate if you *currently* experience difficulty with remembering any of the following:

The order of things (e.g., when cooking, getting ready)	Names of people
Faces of people you know (when they are not present)	Names of objects
Where you are or where you are going	Appointments
Where you leave things (e.g., keys, purse, phone, etc.)	What you should be doing
Recent events (e.g., last meal, recent doctors' visit, etc.)	The order of events
Events that happened long ago (months or years)	Newly learned material

How often you leave stove on, freezer open, etc?.: Daily Weekly Monthly Never

Have you ever been diagnosed as having ADHD or ADD? Yes No

If so, when and by whom? _____

Were you prescribed medication for this? Yes No

If so, what medication? _____

Please circle which of the following *currently* describes you:

Have problems concentrating/paying attention
Make careless errors
Have slow reaction time
Mind appears to go blank at times
Highly distractible
Tend not to be alert/aware of things
Lose train of thought more often than typical/expected

Please indicate if you *currently* experience difficulties with any of the following:

____ Completing an activity in a reasonable amount of time
____ Organizing and planning
____ Doing things in the right order (sequencing)
____ Switching from one activity to another
____ Figuring out how to do new things

Daily Living Skills

If applicable, please indicate when, you began to experience difficulties with any of the following (<u>not</u> due to physical inability):

____ dressing
____ managing household/personal finances
____ bathing/showering
____ remembering and attending appointments
____ eating/feeding self
____ keeping up with medications
____ grooming
____ toileting
____ preparing a list and shopping independently
____ driving safely

Do you have a legal guardian or power of attorney? Yes No

If so, who: _____

Do you have home-health care? Yes No

Do you live in a group home or nursing home? Yes No

Recent Stressors

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

____ Change in job (or loss of job)
____ Change in marital status
____ Death of loved one
____ Moved to a new location

Notes for 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: _____

_____

_____

_____