

# 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        | _____ Diabetes                        | _____ Macular degeneration |
| _____ AIDS/HIV positive             | _____ Dizziness (e.g., vertigo)       | _____ Meningitis           |
| _____ Alzheimer's                   | _____ Encephalitis                    | _____ Migraines            |
| _____ Amputations                   | _____ Endocrine problems              | _____ Movement disorder    |
| _____ Arteriosclerosis              | _____ Epilepsy/seizures               | _____ Multiple sclerosis   |
| _____ Arthritis                     | _____ Fibromyalgia                    | _____ Pancreatitis         |
| _____ Asthma                        | _____ Gastroesophageal reflux disease | _____ Parathyroid disorder |
| _____ Blood disease (e.g., anemia)  | (GERD)                                | _____ Parkinson's Disease  |
| _____ Bowel or bladder incontinence | _____ Heart disease                   | _____ Polio                |

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Brain aneurysm               | <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Regular urinary tract infection |
| <input type="checkbox"/> Brain/Spinal disorder        | <input type="checkbox"/> High cholesterol         | <input type="checkbox"/> Senility/Dementia               |
| <input type="checkbox"/> Brain tumor                  | <input type="checkbox"/> Fetal Alcohol Syndrome   | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Broken bones/fractures       | <input type="checkbox"/> Hydrocephalus            | <input type="checkbox"/> Swallowing disorder             |
| <input type="checkbox"/> Bronchitis                   | <input type="checkbox"/> Hyperthyroidism          | <input type="checkbox"/> Thyroid disease                 |
| <input type="checkbox"/> Cancer: _____                | <input type="checkbox"/> Hypoglycemia             | <input type="checkbox"/> Traumatic brain injury          |
| <input type="checkbox"/> Chronic ear infections       | <input type="checkbox"/> Hypothyroidism           | <input type="checkbox"/> Tumor: _____                    |
| <input type="checkbox"/> Chronic fatigue syndrome     | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Ulcer                           |
| <input type="checkbox"/> Colon disease (Chron's, IBS) | <input type="checkbox"/> Kidney disease           | <input type="checkbox"/> Lyme's Disease                  |
| <input type="checkbox"/> Concussion/head injury       | <input type="checkbox"/> Kidney disorder          | <input type="checkbox"/> Other: _____                    |
| <input type="checkbox"/> COVID-19                     | <input type="checkbox"/> Liver disease            |  |
| <input type="checkbox"/> Cushing's syndrome           | <input type="checkbox"/> Low testosterone         |  |
| <input type="checkbox"/> Down's syndrome              | <input type="checkbox"/> Lung disease             |  |

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):

- | <u>Medication:</u> | <u>Reason for Medication:</u> |
|--------------------|-------------------------------|
| 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):

<u>Name:</u>	<u>Dosage:</u>	<u>Reason:</u>
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:

<u>Name of hospital:</u>	<u>Date and Duration:</u>	<u>Reason:</u>
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



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                               |
| Loss of feeling or numbness                          | Blurred visions                                       |
| Blank spots in vision                                | Double vision   |
| 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 <i>familiar</i> 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

- |                      |                            |
|----------------------|----------------------------|
| <u>Job/Position:</u> | <u>Reason for leaving:</u> |
| 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:

	<u>Presently using</u>	<u>Used in the past</u>
_____ 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                                |
| Euphoria (e.g., feeling on top of the world)                                       | Recurrent/intrusive thoughts                   |
| Feelings of hopelessness   | Resistant to change                            |
| Feelings of worthlessness  | Sadness  |
|  | Sexually inappropriate behaviors               |





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 (not 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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_