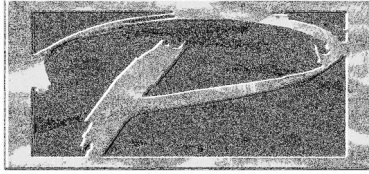


Providence Behavioral Health



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NEUROPSYCHOLOGICAL QUESTIONNAIRE

This questionnaire asks you to respond to a series of questions about you. This type of information is very helpful in making an accurate assessment. Please complete the questions on this form as best you can. We will have the opportunity to discuss them in detail at the time of your appointment. Please circle the answer or write in your answer for all of the questions. Thank you.

PLEASE PRINT

Name: _____ Age: _____ Date of Birth: _____ SSN: _____
Date of Evaluation: _____ Person who referred you for evaluation: _____ Person filling out questionnaire: _____
Physician and address: _____
Insurance Company: _____ Insurance ID: _____ Group #: _____
Home Address: _____ Phone Number: _____

I. SOCIAL HISTORY

Who is at home with you at present? _____ Significant Others / Marriage(s) _____
Please list children & their ages _____
Military Service _____ How far did you go in school _____ GED? _____ Vocational/Training
programs _____ College/Professional degrees _____ Did you ever repeat a grade? _____ If so,
which grade(s) _____ Did you ever require tutoring or special classes? _____ While in school, did you have any learning
difficulties? _____ Currently/last employed as _____ Not currently employed Disabled Primary caretaker
of children or elder Retired How long have you worked at your present job? _____ Previous jobs _____

II. ACTIVITIES OF DAILY LIVING

Do you require assistance bathing, dressing, eating? _____ Use a cane/walker/wheelchair? _____ Takes care of finances at home
(paying bills/balancing checking)? _____ Cooking/ housekeeping? _____ Manages the household (making
appointments, scheduling services, etc.)? _____ Are you an active driver? _____ Has your driving ever been restricted?

III. MEDICAL HISTORY

Please describe any known complications at birth (for example, prematurity) _____ Heart disease Stroke
High cholesterol Diabetes High blood pressure Seizures Cancer Hyperthyroidism (high) Hyperthyroid (low)
High fever Toxic exposure _____ HIV exposure Encephalitis Urinary frequency Constipation Diarrhea
Incontinence of bowel/bladder Sexual Dysfunction Other serious illness or condition _____ Do you have a
Hearing impairment Use a hearing aid Wear corrective lenses? Please list any allergies or drug sensitivities _____
Please list surgeries, serious illnesses or hospitalizations _____
Have you ever smoked? _____ How much? _____ How long did you smoke? (year _____ to year _____)

PBHS/NEUROPSYCHOLOGICAL HISTORY

Do you drink alcohol? _____ If so, about how much do you drink in a week? _____

Has there ever been a time when you drank more heavily? ___ Have others ever thought your drinking was a problem?

Have you ever used marijuana, cocaine, hallucinogens, IV drugs, ecstasy, amphetamines, inhalants or other substances?

If yes, please describe (frequency, duration, age at time of use): _____

Taken prescription medicine other than as prescribed? _____ Had treatment for substance abuse? _____

What MEDICINES (over the counter and prescription) do you take currently? (Please list name, dosage, and frequency):

If parents are living, how is their health? _____ If parents are deceased, do you know what caused their death?

Family history of Parkinson’s Disease, Alzheimer’s Disease or Huntington’s Disease? _____

Have you ever been involved in a motor vehicle accident? ___ If so, please describe injuries _____

Have you ever lost consciousness (been knocked out, fainted, or “blacked out”)? _____

List any head trauma due to physical fights, abuse, falls or sports injuries: _____

Neuroimaging (x-ray, CAT scan, MRI of head) _____ When was the last time you saw your physician?

Next appointment?

IV. NEUROPSYCHOLOGICAL SYMPTOMS

Right-handed Left-handed Ambidextrous Memory problems Problems concentrating Word-finding problems
Problems with balance Get lost frequently Falling Problems planning/organizing Numbness/tingling Muscle
weakness, clumsiness Headaches Vomiting Dizziness Blurred vision Heavy snoring Sleep apnea Tremors
Double vision Ringing in ears Diminished taste & smell Depression Feelings of hopelessness

Anxiety/nervousness Excessive worrying Hallucinations Have you ever thought that life was not worth living? ___

Have you ever attempted to harm yourself? _____ Family history of attempted or completed suicides _____ Have you

have had counseling or medication therapy? ___ Have you ever been hospitalized for mental health treatment?

V. CURRENT STRESSES

Recent life changes _____ Legal involvement _____

Change in appetite Loss of energy Loss of interest in sex Problems at work Relationship issues Grief/loss

Problems falling asleep Problems staying asleep Loss of pleasure in activities previously enjoyed Family Issues

Has anything else happened recently? It might not seem important, but just something you noticed lately? ___

In your own words, what is your reason for having this evaluation? _____
