BACKGROUND QUESTIONNAIRE—ADULT

Confidential

The following is a detailed questionnaire on your development, medical history, and current functioning at home and at work. This information will be integrated with the testing results in order to provide a better picture of your abilities as well as any problem areas. Please fill out this questionnaire as completely as you can.

Client's Name: _____ Today's Date: _____
(If not client, name of person completing this form _____
Relationship to Client _____)
Home address _____ Work _____
Client's Phone (H) _____ (W) _____
Date of Birth _____ Age _____ Sex _____
Place of Birth _____
Primary Language _____ Secondary Language _____
Fluent/Nonfluent (circle one)
Hand used for writing (check one) ☐ Right ☐ Left

Medical Diagnosis (if any) (1) _____

(2) _____

Who referred you for this evaluation? _____
Briefly describe problem: _____
_____
_____

Date of the accident, injury, or onset of illness _____
What specific questions would you like answered by this evaluation?
(1) _____

(2) _____

(3) _____

SYMPTOM SURVEY
For each symptom that applies, place a check mark in the box. Add any comments as needed.

Physical Concerns

Motor	Rt	Lt	Both	Date of Onset
❑ Headaches				_____
❑ Dizziness				_____
❑ Nausea or vomiting				_____
❑ Excessive fatigue				_____
❑ Urinary incontinence				_____
❑ Bowel problems				_____
❑ Weakness on one side of body (Indicate body part)	___	___	___	_____
❑ Problems with fine motor control	___	___	___	_____
❑ Tremor or shakiness	___	___	___	_____
❑ Tics or strange movements	___	___	___	_____
❑ Balance problems				_____
❑ Often bump into things				_____
❑ Blackout spells (fainting)				_____

❑ Other motor problems _____
_____

(*continued*)

Sensory	Rt	Lt	Both	Date of Onset
❑ Loss of feeling/numbness (Indicate where)	___	___	___	_____
❑ Tingling or strange skin sensations (Indicate where)	___	___	___	_____
❑ Difficulty telling hot from cold	___	___	___	_____
❑ Visual Impairment				_____
❑ Wear glasses ☐ Yes ☐ No				
❑ Problems seeing on one side	___	___	___	_____
❑ Sensitivity to bright lights				_____
❑ Blurred vision	___	___	___	_____
❑ See things that are not there	___	___	___	_____
❑ Brief periods of blindness	___	___	___	_____
❑ Need to squint or move closer to see clearly				_____
❑ Hearing loss	___	___	___	_____
❑ Wear hearing aid ☐ Yes ☐ No				
❑ Ringing in ears	___	___	___	_____
❑ Hear strange sounds	___	___	___	_____
❑ Unaware of things on one side of my body	___	___	___	_____
❑ Problems with taste				_____
❑ (___ Increased ____ Decreased sensitivity) Problems with smell				_____
❑ (____ Increased ____ Decreased sensitivity)				
❑ Pain (describe)				_____
❑ Other sensory problems _____				

Intellectual Concerns

Problem Solving	Date of Onset
❑ Difficulty figuring out how to do new things	_____
❑ Difficulty figuring out problems that most others can do	_____
❑ Difficulty planning ahead	_____
❑ Difficulty changing a plan or activity when necessary	_____
❑ Difficulty thinking as quickly as needed	_____
❑ Difficulty completing an activity in a reasonable time	_____
❑ Difficulty doing things in the right order (sequencing)	_____

Language and Math Skills	Date of Onset
❑ Difficulty finding the right word	_____
❑ Slurred speech	_____
❑ Odd or unusual speech sounds	_____
❑ Difficulty expressing thoughts	_____
❑ Difficulty understanding what others say	_____
❑ Difficulty understanding what I read	_____
❑ Difficulty writing letters or words (not due to motor problems)	_____
❑ Difficulty with math (e.g., balancing checkbook, making change, etc.)	_____
❑ Other language or math problems _____	

Nonverbal Skills	Date of Onset
❑ Difficulty telling right from left	_____
❑ Difficulty drawing or copying	_____
❑ Difficulty dressing (not due to motor problems)	_____
❑ Difficulty doing things I should automatically be able to do (e.g., brushing teeth)	_____
❑ Problems finding way around familiar places	_____
❑ Difficulty recognizing objects or people	_____
❑ Parts of my body do not seem as if they belong to me	_____
❑ Decline in my musical abilities	_____

(*continued*)

❑ Not aware of time (e.g., day, season, year) _____
❑ Slow reaction time _____
❑ Other nonverbal problems _____
_____

Awareness and Concentration Date of Onset
❑ Highly distractible _____
❑ Lose my train of thought easily _____
❑ My mind goes blank a lot _____
❑ Difficulty doing more than one thing at a time _____
❑ Become easily confused and disoriented _____
❑ Aura (strange feelings) _____
❑ Don't feel very alert or aware of things _____
❑ Tasks require more effort or attention _____

Memory Date of Onset
❑ Forget where I leave things (e.g., keys, gloves, etc.) _____
❑ Forget names _____
❑ Forget what I should be doing _____
❑ Forget where I am or where I am going _____
❑ Forget recent events (e.g., breakfast) _____
❑ Forget appointments _____
❑ Forget events that happened long ago _____
❑ More reliant on others to remind me of things _____
❑ More reliant on notes to remember things _____
❑ Forget the order of events _____
❑ Forget facts but can remember how to do things _____
❑ Forget faces of people I know (when not present) _____
❑ Other memory problems _____
_____

Mood/Behavior/Personality Rate Severity Date of Onset

	Mild	Moderate	Severe	
❑ Sadness or depression	☐	☐	☐	_____
❑ Anxiety or nervousness	☐	☐	☐	_____
❑ Stress	☐	☐	☐	_____
❑ Sleep problems (falling asleep ☐ staying asleep ☐)				_____
❑ Experience nightmares on a daily/weekly basis				_____
❑ Become angry more easily				_____
❑ Euphoria (feeling on top of the world)				_____
❑ Much more emotional (e.g., cry more easily)				_____
❑ Feel as if I just don't care anymore				_____
❑ Easily frustrated				_____
❑ Doing things automatically (without awareness)				_____
❑ Less inhibited (do things I would not do before)				_____
❑ Difficulty being spontaneous				_____
❑ Change in energy (☐ loss ☐ increase)				_____
❑ Change in appetite (☐ loss ☐ increase)				_____
❑ Increase ☐ or loss ☐ of weight				_____
❑ Change in sexual interest (increase ☐ decline ☐)				_____
❑ Lack of interest in pleasurable activities				_____
❑ Increase in irritability				_____
❑ Increase in aggression				_____
❑ Other changes in mood or personality or in how you deal with people				

_____
_____

Have others commented to you about changes in your thinking, behavior, personality, or mood? If yes, who and what have they said? ☐ Yes ☐ No
_____
_____
_____

(*continued*)

Are you experiencing any problems in the following aspects of your life? If so, please explain:

Marital/Family _____
_____
Financial/Legal _____
_____
Housekeeping/Money Management _____
_____
Driving _____

Overall, my symptoms have developed ☐ slowly ☐ quickly

My symptoms occur ☐ occasionally ☐ often

Over the past six months my symptoms have ☐ improved ☐ stayed the same ☐ worsened

Is there anything you can do (or someone does) that gets the problems to stop or be less intense, less frequent, or shorter? _____
_____

What seems to make the problems worse? _____
_____

In summary, there is
☐ definitely something wrong with me
☐ possibly something wrong with me
☐ nothing wrong with me

What are your goals and aspirations for the future? _____
_____

EARLY HISTORY

You were born: ☐ on time ☐ prematurely ☐ late
Your weight at birth: _____

Were there any problems associated with your birth (e.g., oxygen deprivation, unusual birth position, etc.) or the period afterward (e.g., need for oxygen, convulsions, illness, etc.)? ☐ Yes ☐ No
Describe: _____

Check all that applied to your mother while she was pregnant with you:

❑ Accident
❑ Alcohol use
❑ Cigarette smoking
❑ Drug use (marijuana, cocaine, LSD, etc.)
❑ Illness (toxemia, diabetes, high blood pressure, infection, etc.)
❑ Poor nutrition
❑ Psychological problems
❑ Medications (prescribed or over the counter) taken during pregnancy
❑ Other problems _____

List all medications (prescribed or over the counter) that your mother took while pregnant:
_____

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

	Early	Average	Late
Walking	☐	☐	☐
Language	☐	☐	☐
Toilet training	☐	☐	☐
Overall development	☐	☐	☐

(*continued*)

As a child, did you have any of these conditions:

- ❑ Attentional problems
- ❑ Clumsiness
- ❑ Developmental delay
- ❑ Hyperactivity
- ❑ Muscle weakness
- ❑ Learning disability
- ❑ Speech problems
- ❑ Hearing problems
- ❑ Frequent ear infections
- ❑ Visual problems

MEDICAL HISTORY

Medical problems **prior** to the onset of current condition

If yes, give date(s) and brief description

- ❑ Head injuries _____
- ❑ Loss of consciousness _____
- ❑ Motor vehicle accidents _____
- ❑ Major falls, sports accidents, or industrial injuries _____
- ❑ Seizures _____
- ❑ Stroke _____
- ❑ Arteriosclerosis _____
- ❑ Dementia _____
- ❑ Other brain infection or disorder (meningitis, encephalitis, oxygen deprivation etc.) _____
- ❑ Diabetes _____
- ❑ Heart disease _____
- ❑ Cancer _____
- ❑ Back or neck injury _____
- ❑ Serious illnesses/disorder (Immune disorder, cerebral palsy, polio, lung, etc.) _____
- ❑ Poisoning _____
- ❑ Exposure toxins (e.g., lead, solvents, chemicals) _____
- ❑ Major surgeries _____
- ❑ Psychiatric problems _____
- ❑ Other _____

Are you currently taking any medication?

Name	Reason for taking	Dosage	Date started

Are you currently in counseling or under psychiatric care? ☐ Yes ☐ No

Please list date therapy initiated and name(s) of professional(s) treating you:

_____

_____

Have you ever been in counseling or under psychiatric care? ☐ Yes ☐ No

If yes, please list dates of therapy and name(s) of professional(s) who treated you:

_____

_____

_____

Please list all inpatient hospitalizations including the name of the hospital, date of hospitalization, duration, and diagnosis:

_____

_____

_____

(*continued*)

SUBSTANCE USE HISTORY

I started drinking at age:
☐ less than 10 years old ☐ 10–15 ☐ 16–19 ☐ 20–21 ☐ over 21

I drink alcohol: ☐ rarely or never ☐ 1–2 days/week ☐ 3–5 days/week ☐ daily

I used to drink alcohol but stopped: ___ Date stopped: _____
Preferred type(s) of drinks: _____

Usual number of drinks I have at one time: _____

My last drink was: ☐ less than 24 hours ago ☐ 24–48 hours ago ☐ over 48 hours ago

Check all that apply:
☐ I can drink more than most people my age and size before I get drunk.
☐ I sometimes get into trouble (fights, legal difficulty, work problems, conflicts with family, accidents, etc.) after drinking (specify): _____
☐ I sometimes black out after drinking.

Please check all the drugs you are now using or have used in the past:

	Presently Using	Used in Past
Amphetamines (including diet pills)	☐	☐
Barbiturates (downers, etc.)	☐	☐
Cocaine or crack	☐	☐
Hallucinogenics (LSD, acid, STP, etc.)	☐	☐
Inhalants (glue, nitrous oxide, etc.)	☐	☐
Marijuana	☐	☐
Opiate narcotics (heroin, morphine, etc.)	☐	☐
PCP (or angel dust)	☐	☐
Others (list)	☐	☐

Do you consider yourself dependent on any of the above drugs? ☐ Yes ☐ No
If yes, which one(s): _____

Do you consider yourself dependent on any prescription drugs? ☐ Yes ☐ No
If yes, which one(s): _____

Check all that apply:
☐ I have gone through drug withdrawal.
☐ I have used IV drugs.
☐ I have been in drug treatment.

Has use of drugs ever affected your work performance? _____
Has use of drugs or alcohol ever affected your driving ability? _____
Do you smoke? ☐ Yes ☐ No
If yes, amount per day: _____
Do you drink coffee: ☐ Yes ☐ No
If yes, amount per day: _____

FAMILY HISTORY

The following questions deal with your biological mother, father, brothers, and sisters:
Is your mother alive? ☐ Yes ☐ No
If deceased, what was the cause of her death?
_____
Mother's highest level of education: _____
Mother's occupation: _____

(*continued*)

Does your mother have a known or suspected learning disability? ☐ Yes ☐ No
If yes, describe: _____
Is your father alive? ☐ Yes ☐ No
If deceased, what was the cause of his death?
_____
Father's highest level of education: _____
Father's occupation: _____
Does your father have a known or suspected learning disability? ☐ Yes ☐ No
If yes, describe: _____
How many brothers and sisters do you have? _____
What are their ages? _____
Are there any unusual problems (physical, academic, psychological) associated with any of your brothers or sisters?
If yes, describe: _____

Please check all problems that exist(ed) in close biological family members (parents, brothers, sisters, grandparents, aunts, uncles). Note who it is (was) and describe the problem where indicated

	Who?	Describe
Neurologic disease		
❑ Alzheimer's disease or senility	_____	
❑ Huntington's disease	_____	
❑ Multiple sclerosis	_____	
❑ Parkinson's disease	_____	
❑ Epilepsy or seizures	_____	
❑ Other neurologic disease	_____	_____
Psychiatric illness		
❑ Depression	_____	
❑ Bipolar illness (manic-depression)	_____	
❑ Schizophrenia	_____	
❑ Other		
Other disorders		
❑ Mental retardation	_____	
❑ Speech or language disorder	_____	_____
❑ Learning problems	_____	_____
❑ Attention problems	_____	_____
❑ Behavior problems	_____	_____
❑ Other major disease or disorder	_____	_____

PERSONAL HISTORY

Marital History

Current marital status: ☐ Single ☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed

Years married to current spouse: _____

Dates of previous marriages: From _____ to _____
From _____ to _____

Spouse's name: _____ Age: _____

Spouse's occupation: _____

Spouse's health: ☐ Excellent ☐ Good ☐ Poor

Children (include stepchildren)

Name	Age	Gender	Occupation

Who currently lives at home? _____

Do any family members have any significant health concerns/special needs? _____
_____

(*continued*)

Educational History

	Name of School Attended	Grades and Years Attended	Degree certifications
Elementary			
High school			
College/university			
Trade school			

If a high school diploma was not awarded, did you complete a GED? _____

Were any grades repeated? ☐ Yes ☐ No
Reason: _____

Were there any special problems learning to read, write, or do math? _____
_____

Were you ever in any special class(es) or did you ever receive special services?
☐ Yes ☐ No
If yes, what grade(s) _____ or age? _____
What type of class? _____

How would you describe your usual performance as a student?
❑ A & B
❑ B & C
❑ C & D
❑ D & F

Provide any additional helpful comments about your academic performance: _____
_____
_____

Military Service
Did you serve in the military? ☐ Yes ☐ No
If yes, what branch? _____ Dates: _____
Certifications/Duties: _____
_____
_____
Did you serve in war time? _____ If so, what arena? _____

Did you receive injuries of were you ever exposed to any dangerous or unusual substances during your service?
☐ Yes ☐ No

If yes, explain: _____

Do you have any continuing problems related to your military service? Describe:
_____

Occupational History
Are you currently working? ☐ Yes ☐ No
Current job title: _____
Name of employer: _____
Current responsibilities: _____
Dates of employment: _____
Are you currently experiencing any problems at work? ☐ Yes ☐ No
If yes, describe: _____
_____
Do you see your current work situation as stable? ☐ Yes ☐ No

(*continued*)

Approximate annual income: Prior to injury or illness _____
After injury or illness_____

Previous employers:

Name	Dates	Duties/position	Reason for leaving

Recreation

Briefly list the types of recreations (e.g., sports, games, TV, hobbies, etc.) that you enjoy:

_____
_____

Are you still able to do these activities? _____
_____

Recent Tests

Check all tests that recently have been done and report any abnormal findings.

	Check if normal	Abnormal findings
❑ Angiography	_____	_____
❑ Blood work	_____	_____
❑ CT scan	_____	_____
❑ MRI	_____	_____
❑ PET scan	_____	_____
❑ SPECT	_____	_____
❑ Skull x-ray	_____	_____
❑ EEG	_____	_____
❑ Neurological exam	_____	_____
❑ Other_____	_____	_____

Identify the physician who is most familiar with your recent problems: _____
_____

Date of last vision exam: _____
Date of last hearing exam: _____

Have you had a prior psychological or neuropsychological exam? ☐ Yes ☐ No
If yes, complete the following:
Name of psychologist: _____
Date: _____
Reason for evaluation: _____
Finding of the evaluation: _____
_____

Please provide any additional information that you feel is relevant to this referral:

_____
_____
_____