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BIOGRAPHICAL QUESTIONNAIRE

Please complete the following questions as completely as possible. These questions are pertinent to the evaluation and will help us to use our time together in the most efficient way. **PLEASE BRING THE COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT.**

I. DEMOGRAPHIC INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ MR#: _____

Who referred you here? _____

What is your understanding of the reason you are here? _____

_____

Place of Birth: _____ If not in the US, at what age did you immigrate? _____

Primary Language: _____ If not English, at what age did you learn English? _____

How long have you lived in your present area? _____

Marital Status: Single Married Divorced Separated Widowed

If remarried, please indicate the number of previous marriages: _____

Handedness: Right Left Ambidextrous

If you have children, please list their names, ages, and any health problems:

	Name	Age	Health Problems
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Were you raised by your biological parents? Yes No

If no, who raised you? _____

	Years of Education	Occupation
Your father:	_____	_____
Your mother:	_____	_____

II. EDUCATION

How many years of school did you complete? _____

List any degrees you have obtained: _____

	SCHOOL		Years	Date of	Grade Point
	Name	City	Completed	Graduation	Average
High School	_____	_____	_____	_____	_____
Associates	_____	_____	_____	_____	_____
Bachelors	_____	_____	_____	_____	_____
Masters	_____	_____	_____	_____	_____
Doctorate	_____	_____	_____	_____	_____
Trade School	_____	_____	_____	_____	_____

Have you ever been diagnosed with a learning disability? Yes No

If so, who made the diagnosis and when? _____

Were you ever in any special education classes or require tutoring? Yes No

If so, what classes and when? _____

Have you ever repeated or skipped a grade? Yes No

If so, what grade(s)? _____ Repeated Skipped

Please list your STRONG subjects in school: _____

Please list your WEAK subjects in school: _____

III. EMPLOYMENT HISTORY

List your employment history [*if additional space is needed, please include separate sheet*]:

Current/most recent position title: _____

Name of employer: _____ Dates of employment: _____

Job responsibilities: _____

Reason for leaving: _____

Previous position title: _____

Name of employer: _____ Dates of employment: _____

Job responsibilities: _____

Reason for leaving: _____

Previous position title: _____

Name of employer: _____ Dates of employment: _____

Job responsibilities: _____

Reason for leaving: _____

Previous position title: _____

Name of employer: _____ Dates of employment: _____

Job responsibilities: _____

Reason for leaving: _____

IV. MILITARY HISTORY

If you have any military history, please specify below:

Branch: _____ Dates of service: _____ Highest Rank: _____

Honorable discharge? Yes No If no, please explain: _____

Types of duties performed: _____

V. MEDICAL HISTORY

Did you walk and talk at expected ages? Yes No Don't know

List all current health problems (e.g., injury, high blood pressure, diabetes, high cholesterol)

_____

_____

_____

Have you ever had any serious medical conditions or trauma? (Circle all that apply)

Meningitis	Encephalitis	Seizures	Loss of Consciousness
High Voltage Electrical Shock	Toxic Chemical Exposure	High Fever	Head Injury

Other(s): _____

If yes, please describe: _____

_____

_____

List all **medical hospitalizations**, starting with the most recent:

Dates	Diagnosis/Condition	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all **current medications** and dosage:

Medication	Dosage	How often?	Why do you take this?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Please use the back of this page if there are additional medications)

Do you manage your medications independently (e.g., organizing pills, ordering refills)?	Yes	No
Do you take your medications independently?	Yes	No
Do you have any problems with your vision?	Yes	No
If so, are these problems corrected with lenses?	Yes	No
Do you have any problems with your hearing?	Yes	No
If so, are these problems corrected with hearing aids?	Yes	No

VI. FAMILY MEDICAL HISTORY

Please describe your parents' state of health, listing any known health problems for each.

Mother: _____

Father: _____

Are you aware of any history of neurological or cardiovascular conditions in your immediate family and relatives (including aunts, uncles, grandparents, and first cousins)? **This would include conditions such as strokes, epilepsy, Alzheimer's disease, Parkinson's disease, Huntington's disease, Multiple Sclerosis, heart attacks, high blood pressure, diabetes, etc…** If so, please describe:

_____

_____

_____

Please indicate any deceased relatives, ages, year of death, and cause of death.

Family Member	Age and Year of Death	Cause of Death
Mother		
Father		
Siblings:		

VII. SUBSTANCE USE HISTORY

Substance	CURRENT		PAST		
	Amt per Week	For How Long?	Amt per Week	When?	For How Long?
Tobacco					
Beer					
Wine					
Liquor					
Marijuana					
Cocaine					
Heroin					
Other					
Other					

VIII. PSYCHIATRIC HISTORY

Are you currently receiving mental health services or counseling? Yes No

Have you ever received mental health services or counseling? Yes No

If yes, please list date(s), type of service (e.g., evaluation, therapy, medication), and provider.

Date(s)	Type of Service	Provider (Name & Location)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized for a psychiatric or mental disorder? Yes No

If yes, please specify:

Year:	Length of Stay:	Location:	Diagnosis:	Treatment:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you **currently** prescribed any psychiatric medications (e.g., for anxiety, depression, mood, etc.)? If yes, please specify: Yes No

Medication	Dosage	How often?	Why do you take this?

(Please use the back of this page if there are additional medications)

Please list any psychiatric medications you have been prescribed **in the past**.

Medication	When	Duration of use

(Please use the back of this page if there are additional medications)

Have you any prior psychological/neuropsychological assessments? Yes No

If yes, please list date(s),reason, and provider/location.

Date(s)	Reason	Provider (Name & Location)

Do you know of any history of psychiatric conditions or mental illness in any family members or relatives? **This would include conditions such as alcoholism, depression, manic-depression, bipolar disorder, anxiety, schizophrenia, "nervous breakdown", etc.** If so, please describe…

Family Member	Condition/Mental Illness

IX. LEGAL HISTORY

Have you ever been convicted of a felony? Yes No If yes, please specify:

Date	Type of Offense
_____	_____
_____	_____

Have you ever been convicted of DUI (alcohol or drugs)? Yes No If yes, please specify:

Date	Type of Offense
_____	_____
_____	_____

Are you currently being represented in a workers' compensation claim? Yes No

Are you currently involved in any other type of legal action related to your injury (e.g., personal injury lawsuit)? Yes No

X. CURRENT PROBLEMS

In your own words, please describe your main concern or problem: _____

_____

_____

Do you notice any difficulties with your ability to think, remember, concentrate, use language, or deal with spatial problems? Yes No If yes, please describe:

_____

_____

Please check any of the following problems that apply:

Attention/Concentration

___ Becoming tired easily
___ Having difficulty concentrating
___ Becoming confused easily

Memory

___ Recalling things that have happened to you in the past
___ Recalling things that have been recently been told to you
___ Recalling people's names

___ Recalling where you have left things
___ Recalling how to get places

Language

___ Understanding what is said to you
___ Comprehending what you read
___ Speaking clearly
___ Speaking more slowly
___ Finding the correct words/names for things
___ Writing legibly
___ Spelling correctly

Emotional Problems

___ Tension or anxiety
___ Depression or sadness
___ Mood swings
___ Anger control problems
___ Lack of feelings
___ Lack of motivation
___ Feeling overly energetic/manic
___ Nightmares
___ Thoughts of suicide
___ Hallucinations

Practical Problems

___ Managing money, including handling finances, checkbook, etc.
___ Keeping appointments
___ Changes in ability to handle household chores
___ Changes in driving ability (e.g., getting lost; confusion with directions; accidents; tickets)
___ Ability to do math or spell
___ Changes in the way you relate to/get along with family, friends, etc.

Physical Issues

___ Problems with coordination
___ Weakness
___ Numbness
___ Clumsiness
___ Dizziness
___ Visual problems not corrected by glasses
___ Hearing problems
___ Problems with taste or smell
___ Bladder or bowel control problems
___ Balance problems
___ Changes in weight
___ Changes in sleep
___ Seizures
___ Fainting spells
___ Other:

How have you been sleeping recently? _____

Any trouble falling asleep? Yes No

Any trouble staying asleep? Yes No

Any trouble waking up early? Yes No

How has your appetite been recently? _____

Is your weight stable? Yes No

List any current/past hobbies: _____

_____

_____

Describe your typical day: _____

_____

_____

_____

_____

_____

_____

_____

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR SCHEDULED APPOINTMENT