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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:

	<u>Name</u>	<u>Age</u>	<u>Health Problems</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____



### 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)

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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: \_\_\_\_\_

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

<u>Dates</u>	<u>Diagnosis/Condition</u>	<u>Treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all **current medications** and dosage:

<u>Medication</u>	<u>Dosage</u>	<u>How often?</u>	<u>Why do you take this?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(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.

<u>Family Member</u>	<u>Age and Year of Death</u>	<u>Cause of Death</u>
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.

<u>Date(s)</u>	<u>Type of Service</u>	<u>Provider (Name &amp; Location)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

If yes, please specify:

<u>Year:</u>	<u>Length of Stay:</u>	<u>Location:</u>	<u>Diagnosis:</u>	<u>Treatment:</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

<u>Medication</u>	<u>Dosage</u>	<u>How often?</u>	<u>Why do you take this?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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

<u>Medication</u>	<u>When</u>	<u>Duration of use</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

(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.

<u>Date(s)</u>	<u>Reason</u>	<u>Provider (Name &amp; Location)</u>
_____	_____	_____
_____	_____	_____

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...

<u>Family Member</u>	<u>Condition/Mental Illness</u>
_____	_____
_____	_____
_____	_____
_____	_____

## IX. LEGAL HISTORY

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

Date

Type of Offense

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

Date

Type of Offense

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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: \_\_\_\_\_

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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:

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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 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**