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:_____

Client's Date of Birth:_____ Age: _____ Sex: _____

Primary Language:_____ Secondary Language: _____ Fluent? Y / N

Level of Education: _____ years Highest degree: _____ in what field? _____

Currently Employed? Y / N Type of Employment: _____

Hand used for writing Left / Right / Ambidextrous (circle one)

Medical Diagnosis (if any) 1._____

2._____

Who referred you for this evaluation?_____

Briefly describe the 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.

Physical Concerns

- ☐ Headaches
- ☐ Dizziness
- ☐ Nausea or vomiting
- ☐ Pain (describe)_____
  _____
  _____
- ☐ Excessive fatigue

Motor

- ☐ Urinary incontinence
- ☐ Weakness on one side of body
- ☐ Problems with fine motor control (e.g., use of fingers)
- ☐ Tremor or shakiness
- ☐ Tics or strange movements
- ☐ Balance problems
- ☐ Often bump into things
- ☐ Blackout spells (fainting)

Other physical problems:

_____

_____

_____

_____

Sensory Concerns

- ☐ Loss of feeling/numbness (where?) _____
- ☐ Tingling or strange skin sensations (where?) _____
- ☐ Difficulty telling hot from cold
- ☐ Visual impairment
- ☐ Wear glasses
- ☐ 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
- ☐ Ringing in ears
- ☐ Hear strange sounds
- ☐ Unaware of things on one side of body
- ☐ Problems with taste (circle one) Increased sensitivity Decreased
- ☐ Problems with smell (circle one) Increased sensitivity Decreased
- ☐ Other sensory problems _____

_____

_____

Intellectual Concerns

Executive Skills

- ☐ Difficulty figuring out how to do new things
- ☐ Difficulty with organization
- ☐ Difficulty solving 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

- ☐ Difficulty finding the right word
- ☐ Errors in speech
- ☐ Slurred speech
- ☐ Odd or unusual speech sounds
- ☐ Difficulty expressing thoughts or vague speech
- ☐ Difficulties understanding what others say
- ☐ Difficulty understanding what I read
- ☐ Difficulty writing letters or words (not due to motor problems)
- ☐ Difficulties with math (e.g., balancing checkbook, making change, etc.)
- ☐ Other language or math problems_____

Nonverbal Skills

- ☐ 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
- ☐ Not aware of time (e.g., day, season, year)
- ☐ Slow reaction time
- ☐ Other nonverbal problems_____

_____

_____

Awareness and Concentration

- ☐ 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

- ☐ 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

- ☐ 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 (circle one) loss increase
- ☐ Change in appetite (circle one) loss increase
- ☐ Change in weight (circle one) loss increase
- ☐ Change in sexual interest (circle one) loss increase
- ☐ Lack of interest in pleasurable activities
- ☐ Increase in irritability
- ☐ Increase in aggression

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

_____
_____
_____

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

Marital/Family_____
_____
Academic/Occupational _____
_____
Financial/Legal_____
_____

Are you experience problems with the following activities? (if yes, explain on line below)

Managing Finances/ Bill Paying Y / N _____

_____

Driving / Navigating Y / N _____

_____

Managing Medications/Healthcare Appointments Y / N _____

_____

Cooking/Housekeeping Y / N _____

_____

Overall, my symptoms have developed (circle one) slowly quickly

Over the past six months my symptoms have (circle one)

improved stayed the same worsened

Are you currently taking any medication? (list below)

Name	Reason	Dosage	Name	Reason	Dosage
_____			_____		
_____			_____		
_____			_____		

Have you had a prior psychological or neuropsychological exam? Yes No

If yes: Name of psychologist _____ Date_____
Reason for evaluation _____
Evaluation Findings _____

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

_____
_____