MIND MATTERS MEMPHIS
NEUROPSYCHOLOGY

Amanda M. Gould, Ph.D., HSP
Clinical Neuropsychologist

BACKGROUND NEUROPSYCHOLOGY QUESTIONNAIRE
Please complete this questionnaire before you arrive for your appointment.

Name: _____

Preferred title (circle one): Mr. Miss Ms. Mrs. Dr. Other:_____

Preferred pronoun (circle one): She/Her He/Him They/Them Ze/Zir Xe/XEM Ze/Hir Per/Per

Part of my job is to understand your situation, concerns, and history as wholly as I can. It is very helpful to have some information before beginning the assessment.

If you need help in completing this questionnaire, feel free to have someone help you. If others help you, please make sure the answers are yours. If this form is completed by someone other than the patient, please list the person's name and relationship: _____.

Do you wear Glasses/Contacts? Yes No (If yes, please bring with you to appointment)
Do you use a Hearing Aid? Yes No (If yes, please wear to appointment)
Have you had neuropsychological testing for any reason in the past? Yes No

****Please bring a list of your prescribed and over-the-counter medications to your appointment.**

What do you see as your main problem or concern? (Describe when it started, it is still worsening, if anything makes it better or worse, if it is worse at a particular time of day, how long does it last if it is intermittent, how it has affected you and what medicines/surgery if any, you have already tried for it).

_____

_____

_____

_____

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Mark the correct box for any thinking concerns that bother you using the following key:

Same = No change/concerns **Worse** = Declining over time **Better** = Improving over time

	Worse	Same	Better		Worse	Same	Better
Attention				**Planning and Organizing**			
Focus/Concentration/confusion				Ability to plan			
Doing math in your head				Ability to solve problems			
Misplacing objects				Impulsive decisions, actions, or speech			
Disorganized thoughts/ actions				Remembering how to do things			
Multitasking				Problems starting tasks			
Speed				**Visual Spatial**			
Speed of your thoughts				Processing what you see			
Drowsiness				Use objects incorrectly			
Memory				**Language**			
Learning new information				Mispronouncing words			
Remembering recent information				Can't find words			
Remembering past information				Can't express your thoughts			
Remembering how to get places				Understanding what you read			
Remembering names				Understanding speech			
Repeating questions or stories				Slurring words			
Emotions				**Sleep/Appetite**			
Sadness/crying				Amount of sleep			
Worried				Quality of sleep			
Loss of sense of humor				Acting out dreams			
Loss of interest or motivation				Amount of food eaten			
Irritable/anger				Weight			

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Please indicate whether you need assistance in your day-to-day functioning:

	Independent	Need Assistance	Cannot do
Bathing and grooming			
Dressing			
Toileting (bladder or bowel accidents)			
Eating			
Cooking			
Using telephone/computer/tablet			
Driving or navigating			
Managing medications			
Managing schedule			
Managing finances			
Work/school performance			
Home repairs/cleaning			
Performing hobbies			

Physical Symptoms

Please circle the symptoms that <u>recently or currently</u> bother you.

Vision
Loss of vision
Blurred or double vision
Seeing things that aren't really there

Hearing
Loss of hearing
Hearing sounds or voices others don't

Muscles
Weakness
Rigidity ____

Feeling/Tactile
Numbness or loss of feeling
Tingling or burning
Increased sensitivity to temperature/sweating

Taste and Smell
Change in taste
Change in smell

Movement
Decreased coordination or balance
Tremors

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Problems swallowing or chewing

Shuffling walking
Falls

Personal Medical History

Please check if YOU have a history of the following:

_____ Alcohol abuse
_____ Anesthetic complication
_____ Cancer (type): _____
_____ Chemical exposure (type of chemical and date): _____
_____ Concussion or head injury
How did this injury occur:
_____
Did you lose consciousness? Yes / No
Do you have any memory loss before, during, or after the injury? Yes / No
Did you experience any thinking changes after this injury? Yes / No
Are symptoms from this injury still causing problems in your day-to-day life? Yes / No
If "Yes," in what way(s)?
_____
_____ Cerebral Palsy
_____ Cerebrovascular disease: (Circle one) high blood pressure high cholesterol bypass surgery
_____ Diabetes mellitus: Most recent A1C: _____
_____ Encephalitis or meningitis
_____ Heart attack: Date: _____
_____ Injury from electric shock
_____ Kidney disease: (please circle) Stage I II II IV Dialysis
_____ Liver disease
_____ Loss of consciousness or fainting spell
_____ Oxygen deprivation (near drowning, suffocation, strangulation)
_____ Seizures/Epilepsy
_____ Sleep apnea
_____ Stroke/Transient Ischemic Attack (TIA): Date(s): _____
_____ Other illness, injury, or hospitalization (list): _____

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Diagnostic Testing: (Write where it was performed):

Head CT: Yes / No Date:_____ Location:_____
Head MRI: Yes / No Date:_____ Location:_____
Head EEG: Yes / No Date:_____ Location:_____

Major surgeries (e.g., gastric bypass, heart stents)**:**

_____

_____

_____

Family History

Please check if any close blood relatives have the following:

_____ Family history unknown
_____ Attention-deficit hyperactivity disorder (ADHD)
_____ Learning disability
_____ Seizures
_____ Neurologic illness (e.g., Parkinson's disease, Multiple sclerosis): _____
_____ Dementia (e.g., Alzheimer's, Pick's disease, Frontotemporal disease): _____

Developmental History

Place of Birth: _____
Were there complications during your birth? Yes / No / Unknown
Were you "on time" for learning to walk, talk, potty-training, etc? Yes / No / Unknown
Did you have any serious childhood diseases, surgeries, or medical problems? Yes / No / Unknown
If yes: _____

Mental Health History

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Have you ever experienced any of the following?

Are you currently experiencing more stress than is typical for you? Yes / No

	Currently	In the past	Diagnosed by a professional
Depression	Yes / No	Yes / No	Yes / No
Anxiety	Yes / No	Yes / No	Yes / No
Panic Attacks	Yes / No	Yes / No	Yes / No
Posttraumatic stress disorder	Yes / No	Yes / No	Yes / No
Bipolar disorder	Yes / No	Yes / No	Yes / No
Obsessive thoughts	Yes / No	Yes / No	Yes / No
Hallucinations	Yes / No	Yes / No	Yes / No

Have you ever received treatment for these symptoms? Yes / No

If "Yes," circle which treatments:

Counseling
Medications
Hospitalization

If "No," are you interested in treatment for these issues? Yes / No

How much alcohol do you drink weekly? _____

How much tobacco do you use weekly (e.g., cigarettes, vaping, smokeless tobacco)? _____

Educational History

Did you graduate high school? Yes / No

If "No," how many years of school did you complete? _____

Did you obtain your GED? Yes / No (Year earned: _____)

Average grades in School: A A/B B B/C C C/D D D/F F

Did you attend college? Yes / No

Year's completed_____

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Degree(s) obtained_____

Average grades in School: A A/B B B/C C C/D D D/F F

Were you ever told you had a learning disability or learning problem? Yes / No

Have you ever been diagnosed with ADHD or ADD? Yes / No

Have you ever repeated or skipped a grade? Yes / No (Indicate grade(s)_____)

Have you ever received special education services or academic accommodations? Yes / No

Mother's level of education: _____

Father's level of education: _____

Work History

Are you currently working? Yes / No
Are you retired? Yes / No If "yes" when was the last time you worked? _____

Do you currently receive disability? Yes / No (Year started: _____)

What is the main/primary type of work you've done? _____.
_____
_____
_____.

Are you currently involved in any legal action? _____.
_____
_____
_____.

Other

Please indicate anything else you think that I should know: _____
_____

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