NEUROPSYCHOLOGICAL
REHABILITATION CENTER

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BACKGROUND INFORMATION QUESTIONNAIRE

1. GENERAL INFORMATION

Name and Address

Name: _____ Nickname (if any): _____

Age: _____ Sex: ◯ M ◯ F Date of birth: ___/____/_____ SS#: _____

Home address (include zip code):

_____

_____

_____

Phone: (____) _____-_____

Work address:

_____

_____

_____

Phone (____) _____-_____

Referred by: _____

Finances and Insurance

What are your present sources of financial support? *(Check all that apply)*

◯ Personal earnings ◯ Parents ◯ Savings ◯ Property ◯ Workers' Compensation
◯ Spouse's earnings ◯ Retirement ◯ Investments ◯ SSI ◯ Disability payments
◯ Friends ◯ Trust fund ◯ Inheritance
◯ Other_____

Benefits applied for:	*Monthly benefit*
Social Security or SSI	_____
Workers' Compensation	_____
Disability insurance	_____
Other insurance	_____
Other benefits (specify)	
_____	_____

Personal Information

Sexual identity: ◯ Heterosexual ◯ Bisexual ◯ Other_____
◯ Homosexual ◯ Transsexual

Marital status: ◯ Single ◯ Separated (since _____)
◯ Living together (since _____) ◯ Divorced (date_____)
◯ Married (date _____) ◯ Widowed (date _____)

For each prior marriage, please provide the following information:

	Age at beginning	*Age at ending*	*Type of termination (Divorce, Annulment, etc.)*	*Number of Male children*	*Number of female children*
1st	_____	_____	_____	_____	_____
2nd	_____	_____	_____	_____	_____
3rd	_____	_____	_____	_____	_____

Current spouse or close partner:
Together since: _____ Age: _____ Religion: _____ Ethnic background: _____
Number of his/her prior marriages: _____ Number of children from prior marriages: _____
Years of education: _____ Type of employment: _____
Health problems: _____
Psychiatric problems: _____
Substance abuse problems: _____
Habits or behaviors that concern you: _____

Current living situation:
Type of residence: ◯ Apartment ◯ Condominium ◯ Home ◯ Other_____
Do you own or rent? ◯ Own ◯ Rent
How long have you lived at your current residence? _____
Do you live alone? ◯ Yes ◯ No
If not, who lives with you?

Name(s)	*Relationship*
_____	_____
_____	_____
_____	_____
_____	_____

Legal Information

Please respond Yes or No to each of the following questions:

Yes	*No*	
◯	◯	Are you a citizen of the United States?
◯	◯	Are you currently facing criminal proceedings of any kind?
◯	◯	As an adolescent, were you ever detained by the police?
◯	◯	Have you ever been arrested?
◯	◯	Have you ever been convicted of a crime?
◯	◯	Have you ever been known by or used another name?

If yes, please indicate name(s), including maiden name, and when used:

1. _____ (from age _____ to _____)
2. _____ (from age _____ to _____)
3. _____ (from age _____ to _____)

Is any legal action pending in relation to either a present condition or a previous health problem?

◯ Yes ◯ No

If yes, please describe: _____

Indicate below the year and nature of each suit, both prior and ongoing.

	Year filed	*Nature of suit* (Personal Injury, Medical Malpractice, etc.)	*Ongoing or Resolved?*
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Transportation Information

Do you presently operate a vehicle? ◯ Yes ◯ No

If no, when did you last drive? _____

Reason for no longer driving: _____

Do you have a current driver's license? ◯ Yes ◯ No

If no, when did you last have one? _____

	No. of times	*Year(s)*
Have you ever had a serious accident on a bicycle, scooter, or motorcycle?	_____	_____
Have you been involved in an automobile accident as a driver or passenger?	_____	_____
Have you ever been arrested for driving under the influence of alcohol?	_____	_____
Have you ever had your driver's license revoked or suspended?	_____	_____

Over the past 5 years, how many accidents have you been involved in as the driver (regardless of who was at fault)? _____

2. PERSONAL HISTORY

Background

Parents:

	Father	*Mother*
Ethnic background	_____	_____
Religion	_____	_____
Years of education	_____	_____
Academic degree(s), if any	_____	_____
Employment (before retirement)	_____	_____

Where were you born? _____

If born abroad, at what age did you enter the United States? _____

Prior residences:

Beginning with your birthplace, list all the cities or countries you have lived in.

	From age	*To age*	*City*	*State or Country*
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

Is English your native language? ◯ Yes ◯ No

If not, what is your native language? _____

At what age did you begin to speak English? _____

Other languages you speak, if any: 1. _____ 3. _____

2. _____ 4. _____

Were you raised in a particular religion? ◯ Yes ◯ No

If yes, which? _____

Current religion (if any): _____ How often do you attend services? _____

Please respond Yes or No to each of the following questions:

Yes	*No*	
◯	◯	Were you adopted? If yes, at what age? _____
◯	◯	Were you born a twin? If yes, which type? ◯ Fraternal ◯ Identical
◯	◯	Did any of your siblings die late in pregnancy, at birth, in infancy, childhood, or adolescence?
◯	◯	Did your parents divorce or separate before you were 18 years old? If yes, what was your age at the time of their divorce/separation? _____
◯	◯	Were you raised by a single parent? If yes, which? _____
◯	◯	Were you raised by someone other than your parents? If yes, who? _____
◯	◯	Did you feel abandoned or neglected as a child?
◯	◯	Did either of your parents abuse alcohol or any other substance?
◯	◯	Was either of your parents physically abusive to the other?
◯	◯	Were you subjected to sexual abuse as a child or adolescent?
◯	◯	Were you subjected to physical abuse as a child or adolescent?
◯	◯	Have you ever struck, punched, or injured either a spouse or a romantic partner?
◯	◯	Has any family member, friend, or colleague ever expressed concern regarding your use of alcohol or any other substance?
◯	◯	Have you ever been in an abusive relationship, either as an adolescent or as an adult?
◯	◯	Have you given a child/children up for adoption?
◯	◯	Have you ever lost custody of a child/children?
◯	◯	Have you ever been sexually assaulted? If yes, at what age? _____
◯	◯	Have you ever been physically assaulted? If yes, at what age? _____
◯	◯	Have you ever been tortured? If yes, at what age? _____
◯	◯	Have you ever had a near-death experience?

Please respond Yes or No to each of the following questions:

Yes *No*

◯ ◯ Has a close friend, romantic partner, or spouse ever attempted or committed suicide?

◯ ◯ Have you sustained a major emotional, financial, or personal loss recently?

◯ ◯ Have you ever experienced a life-threatening natural disaster (e.g. earthquake, typhoon, hurricane)? If yes, please describe: _____

◯ ◯ Have you ever been robbed at gunpoint (or with any other weapon)?

Education

	Name of school	*City/State*	*Number of years completed*	*Date finished*	*Grade average (A,B,C,D,F)*	*Diploma Y/N*	*Degree (Specify)*
Elementary	_____	_____	_____	_____	_____		
Jr. High/Middle	_____	_____	_____	_____	_____		
High School	_____	_____	_____	_____	_____	_____	_____
University	_____	_____	_____	_____	_____	_____	_____
Graduate	_____	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____	_____

Total number of years of education completed: _____

In which subjects did you get the best grades? _____

In which subjects did you get the lowest grades? _____

SAT scores (if you know): Verbal_____ Math _____

Academic awards or honors (if any): _____

High School activities (if any): _____

College activities (if any): _____

Have you ever had your IQ tested? ◯ Yes ◯ No ◯ Don't know

Year: _____ Place: _____ Score (if known): _____

Please respond Yes or No to each of the following questions:

Yes *No*

◯ ◯ Did you skip any grades? If yes, which? _____

◯ ◯ Did you repeat or fail any grades? If yes, which? _____

◯ ◯ Did you have difficulty learning to speak, read, write, or spell? If yes, which? _____

◯ ◯ Were you placed in any special education classes? If yes, which? _____

◯ ◯ Were you ever told you were "hyperactive" or had "Attention Deficit Disorder"?

◯ ◯ Were you ever told you were "dyslexic"?

◯ ◯ Were you ever told you had a "learning disability"?

◯ ◯ Were you ever suspended or expelled from high school for academic reasons?

◯ ◯ Were you ever suspended or expelled from high school for disciplinary reasons?

Military Service

Did you serve in the military? ◯ Yes ◯ No

If yes, please provide the following information:

Dates of service: _____

Nature of discharge: _____

Highest rank: _____

Branch of service: _____

Assignment or MOS: _____

Did you see combat action? ◯ Yes ◯ No

Do you have a service-connected disability? ◯ Yes ◯ No

Were you ever court-martialed? ◯ Yes ◯ No

Employment Information

What are your career goals? _____

_____

Are you currently employed? ◯ Yes ◯ No

If yes, please provide the following information:

Current job title: _____

Date current employment began: _____

City and state: _____

Number of hours worked per week: _____

Name of employer: _____

Name of immediate supervisor: _____

Approximate yearly salary or income: _____

Chief duties: _____

_____

Are you satisfied with your present job? ◯ Yes ◯ No

Has your present physical condition resulted in any of the following:

Led to a change in your job title? ◯ Yes ◯ No

Led to a change in your job duties? ◯ Yes ◯ No

Forced you to limit your hours worked? ◯ Yes ◯ No

If yes, previous hours per week _____ Current hours per week _____

If you are not currently employed, please provide the following information

Date last worked: _____

Last employer: _____

City and state: _____

Position last held: _____

Last yearly salary or income: _____

Reason no longer working: _____

Prior employment (start with your earliest position):

	Dates	*Name of employer*	*Job title*	*Hours per week*	*Reason for leaving*
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

Have you ever been fired from a job? ◯ Yes ◯ No If yes, how many times? _____

Have you ever applied for either a pension or compensation for a disability? ◯ Yes ◯ No

If yes, in what years? 1._____ 2._____ 3._____

Interests and Activities

Current exercise (type)	*Frequency (times per week)*	*Duration (length in minutes)*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is your favorite type of music? _____

Do you own any pets? ◯ Yes ◯ No

	Organizations you belong to		*Special talents or interests*
1.	_____	1.	_____
2.	_____	2.	_____
3.	_____	3.	_____

Do you own a firearm of any type? ◯ Yes ◯ No If yes, which type(s)? _____

3. CURRENT PROBLEMS

What problem brings you here for evaluation? _____

_____

Date of injury or concern (if known): _____

How did the problem begin (please check one)?

◯ Suddenly ◯ Over days ◯ Over weeks ◯ Over months ◯ Over years

If your current problem(s) began following an accident, please describe the accident briefly.

_____
_____
_____

What other major problems or concerns do you have, if any?

1. _____
2. _____
3. _____

Head and Neck *(Check all that you currently experience. Where choices are provided, circle any that apply.)*

- ◯ Loss of sense of smell
- ◯ Change in sense of smell or unexplained bad odors
- ◯ Loss of sense of taste or change in sense of taste
- ◯ Blurring, blindness, or double vision
- ◯ Visions or visual hallucinations
- ◯ Intolerance of light
- ◯ Facial numbness, pain, or drooping
- ◯ Hearing loss
- ◯ Hearing ringing or buzzing noises
- ◯ Hearing voices
- ◯ Hearing unexplainable or strange sounds
- ◯ Intolerance of noise
- ◯ Dizziness or problems with balance
- ◯ Difficulty chewing or swallowing
- ◯ Slurring of speech
- ◯ Hoarseness
- ◯ Change in quality of voice

Muscular System *(Check all that you currently experience. Where choices are provided, circle any that apply.)*

- ◯ Loss of strength
- ◯ Loss of coordination
- ◯ Slowness of movements
- ◯ Difficulty walking, gait instability, falling
- ◯ Chronic fatigue
- ◯ Muscle cramps
- ◯ Change in handwriting
- ◯ Shakes or tremors
- ◯ Involuntary movements: jerks, twitches, tic, head movements, hand movements, tongue or lip movements, blinking, other

Sensation *(Check all that you <u>currently experience</u>)*

- ◯ Numbness or loss of sensation
- ◯ Burning or tingling sensations
- ◯ Crawling sensations
- ◯ Pain

Emotion *(Check all that you <u>currently experience</u>)*

- ◯ Anxiety
- ◯ Depression
- ◯ Irritability
- ◯ Apathy
- ◯ Frustration
- ◯ Anger
- ◯ Recurrent fears
- ◯ Panic spells
- ◯ Emotional overreaction
- ◯ Extreme mood swings
- ◯ Change in sense of humor
- ◯ Fear of losing control
- ◯ Crying spells
- ◯ Change in personality
- ◯ Change in sexual interest or drive
- ◯ Decreased capacity for pleasure or joy
- ◯ Feelings of hopelessness

Behavior *(Check all that you <u>currently experience</u>)*

- ◯ Loss of energy
- ◯ Impaired sexual performance
- ◯ Aggression or violence toward other individuals, yourself, animals, objects
- ◯ Eating disturbance: increased appetite, decreased appetite, self-starvation (anorexia), binge eating or overeating (bulimia), self-induced vomiting or laxative use
- ◯ Sleep disturbance: difficulty falling asleep, insomnia, early waking, snoring, nightmares, sleepwalking, napping, daytime sleepiness
  Other: _____
- ◯ Excessive shyness or hesitancy about career advancement, sexual behavior, social life
  Other: _____
- ◯ Loss of control: sexual, verbal, rage attacks, emotional outbursts
  Other: _____
- ◯ Repetitive or compulsive behavior: eating, cleaning, washing, rubbing, sex, gambling, nail biting
  Other: _____
- ◯ Behavioral rituals: _____
- ◯ Involuntary behaviors: laughing, crying, vocalizations, perspiring, heart-racing, rapid breathing
  Other: _____
- ◯ Current driving style: afraid to drive, inhibited, inattentive, reckless
  Other: _____

Intellectual Abilities *(Check all that you <u>currently experience</u>)*

- ◯ Poor concentration
- ◯ Slowness of thinking
- ◯ Decreased clarity of thinking
- ◯ Difficulty finding the right word
- ◯ Use of wrong or inappropriate words
- ◯ Left-right confusion
- ◯ Difficulty with sense of direction
- ◯ Episodes of getting lost
- ◯ Difficulty organizing or planning
- ◯ Difficulty meeting deadlines

Intellectual Abilities *(Check all that you currently experience)*

- ◯ Problems understanding what other people say
- ◯ Problems with reading
- ◯ Problems with spelling
- ◯ Problems with memory
- ◯ Special skills/talents (photographic memory, perfect pitch, etc.)
- ◯ Special mental abilities (telepathy, clairvoyance, etc.)

Thought Process *(Check all that you currently experience. Where choices are provided, circle any that apply.)*

- ◯ Racing thoughts
- ◯ Unusual thoughts
- ◯ Recurrent nightmares
- ◯ Intrusive daytime thought, memories or flashbacks
- ◯ Guilty feelings
- ◯ Mental rituals
- ◯ Preoccupation with finances, sex, cleanliness, etc.
  If yes, please describe: _____
- ◯ Obsessions
- ◯ Phobias
- ◯ Feelings of persecution
- ◯ Suicidal thoughts
- ◯ Recurrent thoughts of death
- ◯ Fears of hurting others
- ◯ Violent fantasies
- ◯ Fantasies of revenge or punishing others
- ◯ Unusual feelings of familiarity or recognition for people, places, situations

4. MEDICAL HISTORY

General Information

Height: _____ Weight: _____ Handedness: ◯ Left ◯ Right ◯ Ambidextrous
Do you wear a hearing aid? ◯ Yes ◯ No
Are you color-blind? ◯ Yes ◯ No
Do you wear eyeglasses or contact lenses? ◯ Yes ◯ No If yes, which: _____
Have you ever felt mistreated by a hospital or health care provider? ◯ Yes ◯ No
Have you ever felt misunderstood or abandoned by a health care provider? ◯ Yes ◯ No

Birth Information

Please respond Yes or No to each of the following questions:

Yes	*No*	
◯	◯	Did your mother have a major illness or a serious accident during the time she was pregnant with you?
◯	◯	Did your mother drink or use drugs during the time she was pregnant with you?
◯	◯	Were you born prematurely? If yes, how many weeks premature were you? _____
◯	◯	Did you suffer any birth-related injury or problems such as Rh blood incompatibility, difficult delivery, “blue baby”? If yes, describe _____

Head Injuries and Other Injuries

List all motor vehicle injuries, work-related injuries, serious falls, fractures, etc. that you have experienced:

Year	*City*	*Cause of accident*	*Type of injury*	*Time unconscious (if any)*	*Length of hospitalization (if any)*
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Surgery History

Have you ever had surgery? ◯ Yes ◯ No

If yes, please provide the following information:

	Nature of surgery	*Hospital*	*City*	*Date*
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Medical Illnesses (Excluding Neurological Disorders)

Please list all major medical illnesses you have experienced and the year of diagnosis:

	Illness	*Year diagnosed*	*Current treating physician (if any)*
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Neurological History

Have you ever consulted a neurologist? ◯ Yes ◯ No

Have you ever consulted a neurosurgeon? ◯ Yes ◯ No

	Name of neurologist (N) or neurosurgeon (NS)	*Indicate (N or NS)*	*Nature of problem*	*Dates of treatment (beginning to ending)*
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Current headaches, if any (if you experience more than one kind of headache, please describe each kind separately):

	1st kind	*2nd kind*	*3rd kind*
Location (forehead, temple, behind left or right eye, etc.)	_____	_____	_____
Age at onset	_____	_____	_____
Frequency (average number per week/month/year)	_____	_____	_____
Intensity (mild, moderate, severe, incapacitating)	_____	_____	_____
Durations (indicate range from shortest or longest for each kind)	_____	_____	_____
Nausea and/or vomiting (Indicate N or V)	_____	_____	_____
Sensitivity to sound or light (indicate S or L)	_____	_____	_____
Associated problems with vision, speech, strength, etc. (if any)	_____	_____	_____
Treatment that works	_____	_____	_____

Other pain, if any:

	1st kind	*2nd kind*	*3rd kind*
Location	_____	_____	_____
Age at onset	_____	_____	_____
Description (dull, aching, stabbing, etc.)	_____	_____	_____
Intensity (mild, moderate, severe, incapacitating)	_____	_____	_____
Present during what % of your waking hours?	_____	_____	_____

Seizures, spells, or attacks, if any:

	1st kind	*2nd kind*	*3rd kind*
Behavior (fainting, vertigo, dizziness, shaking, etc.)	_____	_____	_____
Age at onset	_____	_____	_____
Frequency (average number per week/month/year)	_____	_____	_____
Warning signs or aura (if any)	_____	_____	_____
Specific triggers (if any)	_____	_____	_____

Please indicate if you have ever received any of the following procedures:

	Date	*City*	*Result (if known)*
CT head scan	_____	_____	_____
MRI head scan	_____	_____	_____
Other neuroimaging procedure(s) such as BEAM, SPECT, PET, etc. If so, which: _____	_____	_____	_____
EEG (“brain wave test”)	_____	_____	_____
Evoked potential studies	_____	_____	_____
Lumbar puncture (spinal tap)	_____	_____	_____
Neuropsychological testing	_____	_____	_____

Psychiatric History

Have emotional or psychological concerns ever led you to consult any of the following?

Psychiatrist ◯ Yes ◯ No Counselor ◯ Yes ◯ No

Psychologist ◯ Yes ◯ No Clergy ◯ Yes ◯ No

Therapist ◯ Yes ◯ No Other (specify): _____

If you responded yes to any of the above, please provide the following information:

	Name and degree (PhD, MD, MFCC, LSCW, etc.)	*City*	*Nature of problem*	*Dates of treatment (beginning to ending)*	*No. of visits per wk/mo/yr*
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

Have you ever received psychological testing? ◯ Yes ◯ No

If yes, provide date: _____ Place: _____ By whom: _____

Have you ever attempted suicide? ◯ Yes ◯ No If yes, how many times? _____

Have you ever received electroconvulsive therapy (ECT)? ◯ Yes ◯ No How many times? ____

Have you ever been hospitalized for psychiatric reasons? ◯ Yes ◯ No How many times? ____

If yes, provide the following information for each hospitalization:

	Name of hospital	*City*	*Year*	*Duration of stay*
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Review of Physical Condition

Check <u>if you have ever had</u> any of the following. Please circle specific examples (if provided) or feel free to describe (write in) your specific problem.

Heart and Lungs:

- ◯ Heart attack or chest pain
- ◯ Heart murmur or heart valve problem
- ◯ Infection of the heart or of a heart valve
- ◯ Irregular heart beat
- ◯ High blood pressure
- ◯ Low blood pressure
- ◯ Fainting spells
- ◯ Swollen ankles
- ◯ Shortness of breath when lying down flat
- ◯ Periods of rapid breathing with numbness of lips or fingers
- ◯ Lung disease (asthma, emphysema, tuberculosis, etc.), chronic cough, breathing problems of any kind
- ◯ Other heart or lung problem (describe): _____

Nervous System:

- ◯ Headaches
- ◯ Vision problems (describe): _____
- ◯ Hearing problems (describe): _____
- ◯ Balance problems, dizziness, vertigo (describe): _____
- ◯ Major infections (rheumatic fever, meningitis, encephalitis)
- ◯ Loss of consciousness without head injury, fainting, drop attacks
- ◯ Periods of time for which you have no memory
- ◯ Strokes or any episodes of neurologic impairment
- ◯ Seizures, epileptic fits, or "spells"

Abdomen:

- ◯ Stomach, intestinal or bowel problems, vomiting, ulcers, colitis, blood in stool, tarry stools, diverticulitis, hemorrhoids, persistent diarrhea or constipation, flatulence, excessive belching, incontinence of stool
- ◯ Liver disease, jaundice, hepatitis, cirrhosis, other liver disease
- ◯ Gallbladder problems
- ◯ Other: _____

Urinary:

- ◯ Kidney, urinary, prostate, or bladder problems (increased frequency of urination, need to urinate that interferes with sleep, pain on urination, bed wetting, incontinence of urine, nephritis, uremia, kidney stones, blood in urine)
- ◯ Venereal disease (syphilis, gonorrhea, herpes, genital warts, etc.)

Blood:

- ◯ Anemia, bleeding problems, or easy bruising
- ◯ Blood transfusions
- ◯ Sharing of hypodermic needles
- ◯ Unprotected sexual intercourse with a person known to be, or later determined to be, HIV-positive
- ◯ HIV antibody test? If yes, provide date: _____ Results: _____

Bones:

- ◯ Fractures or dislocations
- ◯ Neck problems
- ◯ Back problems
- ◯ Brittle bones (osteoporosis)
- ◯ Joint problems: pain, swelling, gout, arthritis
- ◯ Torn ligaments or tendons
- ◯ Dental or orthodontic problems that persist (dentures, TMJ-syndrome, etc.)

Skin:

- ◯ Scars
- ◯ Change in skin texture
- ◯ Tattoos
- ◯ Change in pattern or amount of sweating
- ◯ Skin problems (psoriasis, warts, melanoma, cysts, acne, etc.)
- ◯ Cosmetic surgery, including rhinoplasty, face0lift, eyelid surgery, breast augmentation or reduction, liposuction, etc.

Glands (Endocrine):

- ◯ Diabetes (age first diagnosed): _____
- ◯ Thyroid problems (goiter, use of thyroid extract, thyroid surgery, radiation treatment)
- ◯ Other endocrine problems (pituitary, adrenal, pancreas, parathyroid)
- ◯ Intolerance of heat or cold

Miscellaneous:

- ◯ Allergies ◯ Cancer ◯ Noncancerous tumors or growths ◯ Mononucleosis
- ◯ Weight loss that was unintentional ◯ Diagnosis of chronic fatigue syndrome
- ◯ Diagnosis of "Multiple Chemical Sensitivities" or "environmental allergies"
- ◯ Exposure to known toxins (describe): _____

Female History

Please respond Yes or No to each of the following questions:

Yes	*No*	
◯	◯	Do you experience irregular periods?
◯	◯	Do you have problems with sexual intercourse (i.e., pain or absence of orgasm)?
◯	◯	Do you take birth control pills?
◯	◯	Have you ever been diagnosed with premenstrual syndrome?
◯	◯	Have you experienced difficulty conceiving?
◯	◯	Have you ever had a tubal ligation or any other type of tubal surgery?
◯	◯	Have you reached menopause? If yes, at what age? _____
◯	◯	Have you had a hysterectomy? If yes, at what age? _____
◯	◯	Do you take hormones? If yes, at what age did you first take them? _____

Male History

Please respond Yes or No to each of the following questions:

Yes	*No*	
◯	◯	Do you have difficulty achieving or maintaining an erection?
◯	◯	Do you have ejaculatory difficulties?
◯	◯	Have you had a vasectomy?
◯	◯	Have you ever experienced rectal bleeding, injury, or infection associated with sexual behavior?
◯	◯	Have you had prostate surgery?

Substance Use

Please indicate any non-prescribed substances you have used, even if only a few times.

	Age first used	*Age last used*	*Current amount per day or week*
◯ Alcohol	_____	_____	_____

If you consume alcohol now, what types? _____

Maximum amount ever consumed on a regular basis (for weeks or months): _____

Have you ever experienced any of the following?

◯ Blackouts or memory problems ◯ Alcohol-related accident(s) ◯ Delirium tremens
◯ Shakes ◯ Alcohol-related stomach problems ◯ Alcohol-related divorce
◯ Withdrawal seizures ◯ Alcohol-related liver problems ◯ Alcohol-related job loss

◯ Caffeine	_____	_____	_____
◯ Cigarettes	_____	_____	_____
◯ Pipe, cigar, chewing tobacco	_____	_____	_____
If so, which? _____			
◯ Anabolic steroids	_____	_____	_____
◯ Tranquilizers	_____	_____	_____
◯ Barbiturates	_____	_____	_____
◯ Demerol	_____	_____	_____
◯ Glue sniffing	_____	_____	_____
◯ Gasoline sniffing	_____	_____	_____
◯ Other inhalant sniffing	_____	_____	_____
◯ Marijuana	_____	_____	_____
◯ Nitrates (“Poppers”)	_____	_____	_____
◯ MDMA (“Ecstasy”)	_____	_____	_____
◯ Mescaline (Peyote)	_____	_____	_____
◯ Psilocybin (Mushrooms)	_____	_____	_____
◯ LSD (“Acid”)	_____	_____	_____
◯ PCP (“Angel Dust”)	_____	_____	_____
◯ Amphetamines (“Speed”)	_____	_____	_____
◯ Cocaine (“Crack” of Free Base)	_____	_____	_____
◯ Heroin	_____	_____	_____
◯ Morphine or Opium	_____	_____	_____
◯ I.V. drug use (specify): _____	_____	_____	_____
◯ Other (specify): _____	_____	_____	_____

Treatment for Addictive Behaviors

List any substance abuse, 12-step, or other addiction treatment programs in which you have participated (AA, Alanon, Narcotics Anon., Cocaine Anon., Marijuana Anon., Gamblers Anon., Weight Watchers, etc.):

	Name of program	*Dates of treatment (beginning to ending)*	*Location*
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Current Medications

List all prescribed and over-the-counter medicines that you take regularly. Include vitamins, supplements, and immune-enhancers:

	Medication	*Strength*	*Number of tablets per day*	*Month and year started*	*Physician prescribing*
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____

List all medications or other products that you take occasionally:

	Medication	*Strength*	*Number of tablets per day*	*Month and year started*	*Physician prescribing*
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

Previous Medications

List those medications that either have not been helpful or that you were forced to stop taking:

	Medication	*Maximum dosage per day*	*Taken for how long*	*Date last taken*	*Reason stopped*
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____

Allergies and Adverse Reactions

List any medications or substances to which you have had a significant allergic or adverse reaction:

	Medication or substance	*Type of allergic or adverse reaction*
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

Other Therapies (Past and Current)

List all treatment programs in which you have participated:

	Location	*Dates of treatment (beginning to ending)*	*No. of visits per wk/mo/yr*
Head injury rehab. (inpatient)	_____	_____	_____
Head injury rehab. (outpatient)	_____	_____	_____
Physical therapy	_____	_____	_____
Chiropractic treatment	_____	_____	_____
Biofeedback	_____	_____	_____
Massage	_____	_____	_____
Hypnosis	_____	_____	_____
Other: _____	_____	_____	_____

Do you practice meditation? ◯ Yes ◯ No

If yes, indicate the type of meditation: _____

Year you began: _____ How many times do you meditate per week? _____

Do you have any problems with sleep onset? ◯ Yes ◯ No

Do you have any problems with sleep maintenance? ◯ Yes ◯ No

Avg. number of hours of sleep per night:_____

Avg. number of times waking up during the night: _____

5. FAMILY HISTORY

	Name	*Age (if living)*	*Medical, surgical, neurological, psychiatric, or substance abuse problems*	*Age at death (if deceased)*	*Cause of death*	*Year of death*
Mother:	_____	_____	_____	_____	_____	_____
Father:	_____	_____	_____	_____	_____	_____
Adoptive mother:	_____	_____	_____	_____	_____	_____
Adoptive father:	_____	_____	_____	_____	_____	_____
Brothers and sisters:						
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____

Name	*Age (if living)*	*Medical, surgical, neurological, psychiatric, or substance abuse problems*	*Age at death (if deceased)*	*Cause of death*	*Year of death*
Brothers and sisters by adoption , half-siblings, or step siblings:					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Children:					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Is there a family history of any of the following neurological problems? *(Please respond Yes or No to each)*

Yes	*No*		*Specify which relative(s)*	*Approximate age at onset*
◯	◯	Headache	_____	_____
◯	◯	Aneurysm or vascular malformation	_____	_____
◯	◯	Movement disorder	_____	_____
◯	◯	Shakes or tremors	_____	_____
◯	◯	Convulsions, seizures, or epilepsy	_____	_____
◯	◯	Sleep disorder	_____	_____
◯	◯	Intellectual deterioration before age 60	_____	_____
◯	◯	Dyslexia or other learning disorder	_____	_____
◯	◯	Hyperactivity or Attention Deficit Disorder	_____	_____
◯	◯	Mental retardation	_____	_____
◯	◯	Huntington's disease	_____	_____
◯	◯	AIDS	_____	_____
◯	◯	Syphilis	_____	_____
◯	◯	Other neurological disorder	_____	_____

Is there a family history of any of the following psychiatric problems? *(Please respond Yes or No to each)*

Yes	*No*		*Specify which relative(s)*	*Approximate age at onset*
◯	◯	Depression	_____	_____
◯	◯	Mania	_____	_____
◯	◯	Suicide or suicide attempts	_____	_____
◯	◯	Anxiety or panic disorder	_____	_____
◯	◯	Obsessive compulsive disorder	_____	_____
◯	◯	Eating disorder	_____	_____
◯	◯	Paranoia	_____	_____
◯	◯	Schizophrenia	_____	_____
◯	◯	Autism	_____	_____
◯	◯	Substance abuse	_____	_____
◯	◯	Hospitalization for mental illness	_____	_____
◯	◯	Outpatient treatment for mental illness	_____	_____
◯	◯	Untreated mental illness	_____	_____

Is there any other known inherited illness in your family? ◯ Yes ◯ No

If yes, please describe: _____

Name of your primary doctor: _____

Specialty (if any): _____

Address: _____

_____

Phone: (_____) _____-_____

Who completed this questionnaire? _____

If other than patient, indicate relationship to patient (parent, spouse, attorney, etc.): _____

How much time was spent completing this questionnaire? _____

Signature of patient: _____ Date: _____