

River Valley Neuropsychology

Patient History Questionnaire

Confidential Information

In preparation for your evaluation, please complete the following questionnaire by answering all items completely and in as much detail as possible. Feel free to write on the last page or use additional sheets, as necessary. If you are able, complete this form independently. Otherwise, you may have a relative or friend assist you. Please bring this completed questionnaire and supporting medical, assessment, and academic records with you to your evaluation.

Patient Information	
Name: _____	Date of Birth: _____
Mailing address: _____	Age: _____
_____	Handedness: Left Right
Preferred phone #: _____	

Form completed by: **Patient** **Other:** _____

Referral Information: Who referred you for this evaluation? _____

Prioritizing Personal and Family Goals

What do you and your family hope to accomplish during your evaluation at Gaylord? Please provide your views on the important issues you would like to be addressed:

Top priority issue: _____

Second most important issue: _____

Other important issue(s): _____

Previous Evaluations, Diagnoses, and Treatments: Have you undergone any of the following evaluations or tests? Please place an X in any of the boxes next to tests or consultations that you have undergone.

Note: please bring in copies of all the reports of these tests. If you had a CT, MRI, SPECT, or PET scans, it is important that you bring a CD with the data from the scans stored on the disk (not just reports).

- Seen a Neurologist
- Seen a Psychiatrist
- Neuropsychological testing
- Spinal tap or lumbar puncture
- Blood or urine studies
- EEG (electroencephalogram)
- EMG (electromyogram)
- CT (computed tomography)
- MRI (magnetic resonance imaging)
- SPECT (single photon emission computed tomography)
- PET (positron emission tomography)
- PSG (polysomnogram, or sleep study)

What diagnosis or diagnoses have you or other physicians suggested to explain your symptoms?

Cognitive Symptoms (changes in thinking): Please check the space next to any of the symptoms below that apply to you.

Attention & Concentration:

- Difficulty focusing/concentrating on tasks
- Often lose your train of thought
- Easily distracted
- Hard to multi-task
- Have to re-read information multiple times
- Other: _____

Thinking or processing speed:

- Takes longer to do things
- Thoughts seem slower
- Other: _____

Speech & Language:

- Trouble finding words
- Use the wrong word or switch words
- Harder to express yourself
- Change in spelling
- Difficulty reading due to comprehension problems
- Trouble understanding when others are speaking

- Change in speaking pattern, speech is: slurred louder softer rambling nasal
- Other: _____

Organization and Problem Solving (Executive Functions):

- Harder to be organized
- Trouble making decisions
- Difficulty planning for events
- Difficulty problem solving (i.e., hard to come up with solutions to new problems, hard to strategize)
- Trouble cooking for a large group
- Trouble making change
- Difficulty calculating a tip
- Other: _____

Memory:

- Frequently misplace objects (keys, glasses)
- Poor short term memory—very forgetful
- Difficulty remembering plans you have made for the day
- Difficulty recalling details of events or conversations that happened recently
- Tendency to mix up details
- Trouble following plot lines in movies or in books
- Told you repeat yourself
- Forget events that happened long ago (months, years)
- Tend to talk more about the past than present
- Told you make stories up
- Rely heavily on posted notes, phone, calendar, & other reminders to stay organized and keep track of important information
- Easier to recall information if someone “jogs” your memory
- Recall things minutes later
- Trouble remembering appointments
- Forget to pay bills
- Forget to take medications
- Difficulty remembering how to get to familiar places
- Gotten lost when walking or driving
- Left an appliance on (i.e., stove)
- Other: _____

Visual-spatial:

- Difficulty reading a map
- Rely heavily on a GPS to navigate
- Change in sense of direction
- Bump into things
- More clumsy—drop things
- Reach for something and miss
- Difficulty recognizing objects
- Harder to park a car
- Difficulty with depth perception
- Other: _____



Time Course of Cognitive Symptoms: Please check the following boxes that best describe the onset and progression of the changes in thinking & memory.

Manner of Onset

The symptoms developed:

- Suddenly- there were no symptoms at all until something suddenly happened on one day
- Quickly over several days or a few weeks
- In a rather subtle manner and gradually became worse over months or years

Recency of onset

The symptoms began:

- Less than 6 months ago
- 6-12 months ago
- More than 12 months ago

Course of progression

Since the symptoms started months or years ago, the symptoms have:

- Gradually improved
- Remained relatively stable- not gotten worse, but also not gotten better
- Fluctuated- some days or weeks have been far better or worse than other days or weeks
- Gradually gotten worse over time

Changes in Mood and Behavior: Have you experienced any of the following symptoms, or have any of your relatives or friends been concerned about these symptoms in you? Please place an X in any of the boxes next to the symptom.

- Sadness
- Feelings of depression
 - Hopelessness
 - Helplessness
 - Loss of interest in things previously enjoyed
 - Have had thoughts that life is not worth living
 - Considered suicide
- More anxious or nervous than usual
- Panic attacks
- Change in behavior or personality
- More irritable or moody than usual
- More euphoric (elevated or upbeat mood) or outgoing than usual
- Crying/laughing more easily (i.e., tear up for seemingly no reason)
- Easily agitated
- Wandering or pacing
- Poor frustration tolerance (easily frustrated or annoyed)
- Frequently lose your temper
- Impulsive, rash or careless actions, such as new-onset gambling, taking things, stealing, buying or selling property without regard for consequences
- Loss of interest, drive, or motivation, such passivity, lack of spontaneity, does not engage in previously rewarding activities
- Decreased initiation of behavior, such as needing prompting to begin or continue routine activities, less likely to initiate or continue conversations

- Have you seen objects, animals, or people that were actually not there
- Have you perceived objects as being something different than they actually are, such as perceiving a chair is a dog
- Have you tended to believe something is true when relatives or friends disagreed, such as thinking someone was in the house when nobody was actually there, or thinking someone stole something when this did not happen
- Have you believed that someone was actually someone else, or believed someone had been replaced by an identically-appearing imposter
- Déjà vu (such as the thought of being somewhere you have not been before or seeing something/someone not seen before)
- Socially inappropriate behavior
 - Such as touching or kissing strangers, public urination, etc.
 - Loss of manners or interpersonal respect, such as crude or sexually explicit remarks, jokes, or opinions which may be offensive to others
 - Continue talking despite other's attempts to end a conversation
 - Flatulence, touching private body parts, belching or spitting
 - Loss of respect for interpersonal space
- Loss of sympathy or empathy
 - Less responsive to other people's needs and feelings, such as making hurtful comments, disregard for other people's pain, making jokes at a funeral
- Simple repetitive movements, such as tapping, clapping, rubbing, scratching, picking at skin or clothing, pursing lips, lip smacking
- Complex, compulsive or ritualistic behaviors, such as counting and cleaning rituals
 - repetitive trips to the bathroom,
 - walking fixed routes repetitively
 - Preoccupied by checking locks, or making sure drapes or blinds are closed
 - Excessive hand washing or showering
 - Hoarding or collecting objects
 - Tendency to touch or line objects up
 - Collecting objects
 - Superstitious rituals
- Repeating words or phrases that have no communicative value (i.e., getting stuck on a certain phrase)
- Excessive humming or singing
- Change in food preferences, such as craving carbohydrates- particularly sweets, baked goods, pasta
- Binge eating- continues to eat despite feeling full
- Increased consumption of alcohol or cigarettes, compulsive smoking, chewing tobacco or gum
- New appreciation for or change in preferred style of art, painting, sculpting, woodworking, music
- Neglect personal hygiene (not showering regularly, less concern about appearance, need to remind to change clothes, bathe or brush teeth)
- Change in religious or political views
- Change in sex drive- marked increase or decrease
- Vivid dreams
- Other: _____



Time Course of Mood/Behavior Symptoms: Please check the following boxes that best describe the onset and progression of the changes in mood and behavior.

Manner of Onset

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- Quickly over several days or a few weeks
- In a rather subtle manner and gradually became worse over months or years

Recency of onset

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- Less than 6 months ago
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- More than 12 months ago

Course of progression

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- Remained relatively stable- not gotten worse, but also not gotten better
- Fluctuated- some days or weeks have been far better or worse than other days or weeks
- Gradually gotten worse over time

Physical Symptoms: Please check the space next to any of the symptoms below that apply to you.

- Unsteady while standing or walking
- Shuffling gait
- Difficulty walking
- Slowness of movement
- Stooped posture
- One arm/leg stiff when walking
- Neck stiffness
- Balance problems
- Falling
- Difficulty going from sitting to standing position
- Difficulty turning over in bed
- Lightheadedness upon standing
- Near fainting, or full fainting upon standing
- Dizziness
- Repeated twitches in any muscles
- Muscles getting smaller (atrophy)
- Muscle cramps
- Reduced strength
- Tremor in hands/arms when reaching, holding utensils, or cups
- Tremor in hands/arms resting
- Reduced arm swing when walking
- Involuntary wandering of an arm or leg
- Weakness in hands, arms, legs or feet
- Numbness or tingling
- Difficulty buttoning buttons, tying shoes, zipping zippers
- Soft voice
- Loss of facial expressions
- Change in handwriting
- Lack of energy or stamina
- Tend to be drowsy/lethargic during the day, despite getting enough sleep

- Tend to sleep/nap 2 or more hours during the day
- Snore
- Pain
 - o If so, where? _____
- Headaches or migraines
 - o If so, how frequently do they occur? _____
 - o What is their typical intensity on a scale of 1 (no pain) to 10? _____
 - o What makes them better? _____
 - o What do they prevent you from doing? _____
- Hearing problems
 - o Reduced hearing
 - o Ringing in ears
- Vision problems
 - o Eyesight getting worse
 - o Eyesight getting worse, yet eye doctor says vision is okay
 - o Double vision
 - o Bright lights are bothersome
- Loss of smell
- Loss of taste
- Nausea/vomiting
- Trouble swallowing, tendency to choke
- Drooling
- Change in appetite
- Significant loss/gain in weight
- Greasiness/dryness of the face
- Lack of sweating even when warm or hot temperatures
- Difficult to regulate body temperature
- Constipation
- Urinary Incontinence
- Stool incontinence
- Erectile dysfunction
- No longer able to have orgasms
- Other: _____



Time Course of Physical Symptoms: Please check the following boxes that best describe the onset and progression of the changes in physical functioning.

Manner of Onset

The symptoms developed:

- Suddenly- there were no symptoms at all until something suddenly happened on one day
- Quickly over several days or a few weeks
- In a rather subtle manner and gradually became worse over months or years

Recency of onset

The symptoms began:

- Less than 6 months ago
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Course of progression

Since the symptoms started months or years ago, the symptoms have:

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- Remained relatively stable- not gotten worse, but also not gotten better
- Fluctuated- some days or weeks have been far better or worse than other days or weeks
- Gradually gotten worse over time

Sleep Schedule: Please check which time in the evening/night is closest to when you typically fall asleep?

- Before 8 pm
- 8 pm
- 9 pm
- 10 pm
- 11 pm
- 12 midnight
- After 12 midnight

Please check which time in the morning is closest to when you typically wake in the morning?

- Before 6 am
- 6 am
- 7 am
- 8 am
- 9 am
- 10 am
- After 10 am

Please estimate how many hours of sleep you actually obtain every night on average?

- Less than 5 hrs
- 6 hrs
- 7 hrs
- 8 hrs
- 9 hrs
- 10 hrs
- More than 10 hrs

Do you experience problems falling asleep? **Yes No**

If yes, does this bother you?

- It bothers me a little
- It bothers me moderately
- It bothers me greatly
- No, it does not bother me

Do you experience problems staying asleep? **Yes No**

If yes, does this bother you?

- It bothers me a little
- It bothers me moderately
- It bothers me greatly
- No, it does not bother me

Nutrition: Do you follow any type of specialized diet? **Yes No**

Diabetic Low fat Low sodium Paleo Gluten-free Vegetarian Vegan Other: _____

Breakfast: What do you typically eat for breakfast? _____

- What time to you usually eat breakfast? _____
- What do you drink? Nothing coffee tea water juice milk other
- I tend to skip breakfast

What do you snack on in between breakfast and lunch? _____

What do you drink? Nothing coffee tea water juice milk beer/wine other

Lunch: What do you typically eat for lunch? _____

- What time to you usually eat lunch? _____
- What do you drink? Nothing coffee tea water juice milk beer/wine other
- I tend to skip lunch

What do you snack on in between breakfast and lunch? _____

What do you drink? Nothing coffee tea water juice milk beer/wine other

Dinner: What do you typically eat for dinner? _____

- What time to you usually eat dinner? _____
- What do you drink? Nothing coffee tea water juice milk beer/wine other
- I tend to skip dinner

What do you snack on after dinner? _____

What do you drink? Nothing coffee tea water juice milk beer/wine other

Daily Functioning: For the following questions, please place a checkmark next to the description that best captures your abilities:

Using the telephone:

- Able to look up numbers, dial telephone, and receive and make calls without help
- Able to answer telephone or dial operator in an emergency, but need special telephone or help in getting #'s and/or dialing
- Unable to use the telephone

Traveling:

- Able to drive own car or to travel alone on buses or in taxis
 - Have you recently had any accidents or near misses? **Yes No**
- Able to travel, but need or prefer someone to travel with
- Unable to travel independently

Shopping:

- Able to take care of all food and clothes shopping with transportation provided
- Able to shop, but need or prefer someone to shop with
- Unable to shop

Preparing meals:

- Able to plan and cook full meals
- Able to prepare light foods, but unable to cook full meals alone
- Unable to prepare any meals

Housework:

- Able to do heavy housework (i.e., scrub floors)
- Able to do light housework, but need help with heavy tasks
- Unable to do any housework

Taking medicine:

- Able to prepare and take medications in the right dose at the right time
- Able to take medications, but need reminding or someone to prepare them
- Unable to take medications independently

Managing money:

- Able to manage buying needs (i.e., write checks, pay bills)
- Able to manage daily buying needs, but need help managing checkbook
- Unable to handle money independently

Medical/Health History:

Height: _____

Weight: _____

Please note whether you or any of your relatives have been diagnosed with any of the conditions listed below.

	Self	Family Member
Diabetes (Type I)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (Type II)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Bypass surgery	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Mini stroke	<input type="checkbox"/>	<input type="checkbox"/>
TIA	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
Vit B12 deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Type: _____	<input type="checkbox"/>	<input type="checkbox"/>
Type: _____	<input type="checkbox"/>	<input type="checkbox"/>
Type: _____	<input type="checkbox"/>	<input type="checkbox"/>

	Self	Family Member
Liver problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Toxic exposures	<input type="checkbox"/>	<input type="checkbox"/>
Lyme Disease	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Concussion/TBI	<input type="checkbox"/>	<input type="checkbox"/>
How many? ____	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive Compulsive Dis.	<input type="checkbox"/>	<input type="checkbox"/>
Genetic disorder of any kind	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
food	<input type="checkbox"/>	<input type="checkbox"/>
environmental	<input type="checkbox"/>	<input type="checkbox"/>
Dementia (not sure what type)	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Lewy Body Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Huntington's disease	<input type="checkbox"/>	<input type="checkbox"/>
Other Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Surgical History: Please list any surgeries you have had.

Mental Health History:

Have you ever seen a counselor or therapist? **Yes** **No**
Do you currently have a therapist? **Yes** **No**

Have you ever been prescribed psychiatric medications? **Yes** **No**

Do you currently have a psychiatrist? **Yes** **No**

Have you ever been psychiatrically hospitalized? **Yes** **No**

Please list any psychiatric hospitalizations you have had, if applicable (year, location, reason):

Medications: Please list here any medications you are *currently* using, including dosage and frequency:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

What kind of reminders do you use? None Pill Box Alarm Reminder/phone call Other

Which of the following medications have you used in the *past*? Please place an X in any of the boxes next to medications you have used in the past.

- | | |
|---|--|
| <input type="checkbox"/> Aricept (donepezil) | <input type="checkbox"/> Sinemet (carbidopa/levodopa) |
| <input type="checkbox"/> Razadyne /Reminyl (galantamine) | <input type="checkbox"/> Mirapex (pramipexole) |
| <input type="checkbox"/> Excelon (rivastigmine) | <input type="checkbox"/> Requip (ropinirole) |
| <input type="checkbox"/> Excelon patch (rivastigmine) | <input type="checkbox"/> Azilect (rasagiline) |
| <input type="checkbox"/> Namenda (memantine) | <input type="checkbox"/> Strattera (atomoxetine) |
| <input type="checkbox"/> Haldol (haloperidol) | <input type="checkbox"/> Antidepressants (such as Prozac, Zoloft, Celexa, etc) |
| <input type="checkbox"/> Thorazine (chlorpromazine) | <input type="checkbox"/> Sleeping meds (such as Ambien, clonazepam, trazodone) |
| <input type="checkbox"/> Risperdal (risperidone) | <input type="checkbox"/> Cholesterol meds (such as Crestor, Zetia) |
| <input type="checkbox"/> Zyprexa (olanzapine) | <input type="checkbox"/> Blood pressure meds (such as Lisinopril) |
| <input type="checkbox"/> Seroquel (quetiapine) | <input type="checkbox"/> Diabetes meds (such as Metformin) |
| <input type="checkbox"/> Clorazil (clozapine) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Reglan (metachlorpramide) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Compazine (prochlorperazine) | |
| <input type="checkbox"/> Provigil (modafinil) | |
| <input type="checkbox"/> Ritalin (methylphenidate) | |
| <input type="checkbox"/> Dexedrine (dextroamphetamine) | |
| <input type="checkbox"/> Adderall (dextro/metamphetamine) | |
| <input type="checkbox"/> Nuvigil (armodafinil) | |

Current Living Arrangements

What are your current living arrangements?

- Your own home
- Apartment or condominium- independent living
- Assisted living residence
- Skilled nursing care facility or nursing home

With whom do you live? Please check all that apply:

- I lived alone
- Spouse
- Companion
- Child or children
- Other

If you have someone involved in your care in any way (such as assists you with medications, finances, driving, etc.), how close do they live to you?

- In the same house, condominium, or residence
- In a different residence but lives 30 miles or less from you
- More than 30 miles from you

List your recreational interests or hobbies you enjoy. If appropriate, describe how these have been affected by your medical condition.

Education:

Highest grade/degree completed in school _____ Year graduated _____

If college, what was your major? _____

What were your strengths in school? English Math History Language Social Studies Arts Other: _____

What were your weaknesses in school? English Math History Language Social Studies Arts Other: _____

Were you ever held back any grades? **Yes No** If so, what grades? _____

Did you receive any special assistance/special education?: **Yes No**

Were you ever diagnosed with a reading disorder, dyslexia, attention-deficit disorder or another learning disability? **Yes No**

What grades did you earn during elementary school and particularly high school?

- Generally As and Bs
- Generally Bs and Cs
- Generally Cs and Ds
- I found school to be very difficult

What grades did you earn during college and postgraduate work (if applicable)?

- Generally As and Bs
- Generally Bs and Cs
- Generally Cs and Ds
- I found college to be very difficult

List any extracurricular school activities in which you participated (e.g., sports, clubs, etc.):

Employment:

Are you currently employed? **Yes** **No** If not, when did you last work? _____

How many hours a week do you work? _____

List your work history beginning with your current job and going backwards.

Compensation/Litigation:

- | | | |
|---|------------|-----------|
| Do you currently receive Social Security Benefits? | Yes | No |
| Do you currently receive Worker’s Compensation Benefits? | Yes | No |
| Are you currently receiving <u>any</u> disability compensation as a result of your illness? | Yes | No |
| Are you currently receiving disability compensation for <u>past</u> illnesses? | Yes | No |
| Are you applying for any disability benefits? | Yes | No |
| Are you currently involved in a lawsuit or other legal action? | Yes | No |

Current Attorney: List the name and contact information for any legal counsel currently assisting you:

Do you have a will? **Yes** **No** Do you have a Living Will? **Yes** **No**

Have you given someone Power of Attorney? **Yes** **No**

To the best of my knowledge, my responses in this questionnaire are an accurate representation of my health and behavioral history.

Patient signature

Date