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

- Change in sex drive- marked increase or decrease
- 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
  - Neglect personal hygiene (not showering regularly, less concern about appearance, need to remind to change clothes, bathe or brush teeth)
- 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

- Hallucinations, suspiciousness and mistaken impressions
  - Have you seen objects, shadows, animals or people that others did not see? (such as spiders or small animals in the corner of the room)
  - 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)
- Vivid dreams (they seem so real you are often not sure if they really happened or not or they are incredibly detailed and elaborate)
  - Trouble when first waking up—knowing whether you are still asleep or awake
- 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
- 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
- Change in religious or political views
- 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
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

PHYSICAL SYMPTOMS: Please check the space next to any of the symptoms below that apply to you.

- Motor/balance
  - Unsteady while standing or walking
  - Shuffling gait
  - Difficulty walking
  - Slowness of movement
  - Stooped posture
  - One arm/leg stiff when walking
  - Reduced arm swing when walking
  - Neck stiffness
  - Balance problems
  - Falling
  - Difficulty going from siting to standing position
  - Difficulty turning over in bed
- Dizziness
  - Lightheadedness upon standing
  - Near fainting, or full fainting upon standing
  - Vertigo (room spinning)
- Muscles/tremor
  - Reduced strength or weakness in hands, arms, legs or feet
  - Loss of muscle mass
  - Tremor in hands/arms when reaching, holding utensils, or cups
  - Tremor in hands/arms resting
  - Involuntary wandering of an arm or leg
  - Numbness or tingling
  - Difficulty buttoning buttons, tying shoes, zipping zippers
  - Change in handwriting
- Speaking/voice
  - Soft voice

- Loss of facial expressions

- 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
  - If so, where? _____
- Headaches or migraines
  - If so, how frequently do they occur? _____
  - What is their typical intensity on a scale of 1 (no pain) to 10? _____
  - What makes them better? _____
  - What do they prevent you from doing? _____
- Hearing problems
  - Reduced hearing
  - Ringing in ears
- Vision problems
  - Eyesight getting worse
  - Eyesight getting worse, yet eye doctor says vision is okay
  - Double vision
  - Bright lights are bothersome
- Loss of smell
- Loss of taste
- Nausea/vomiting
- Trouble swallowing, tendency to choke
- Drooling
- Change in appetite (less? More?)
- 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
- ☐ 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

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

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

If yes, does this bother you?
- o It bothers me a little
- o It bothers me moderately
- o It bothers me greatly
- o 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 1)	☐	☐
Diabetes (Type II)	☐	☐
Heart Disease	☐	☐
Heart Attack	☐	☐
Bypass surgery	☐	☐
High Cholesterol	☐	☐
High Blood Pressure	☐	☐
Stroke	☐	☐
Mini stroke	☐	☐
TIA	☐	☐
Aneurysm	☐	☐
Asthma	☐	☐
COPD	☐	☐
Sleep apnea	☐	☐
Vit B12 deficiency	☐	☐
Cancer	☐	☐
Type: _____	☐	☐
Type: _____	☐	☐
Type: _____	☐	☐
Liver problems	☐	☐
Kidney problems	☐	☐
Epilepsy/seizures	☐	☐
ADHD	☐	☐
Toxic exposures	☐	☐
Lyme Disease	☐	☐
Migraines	☐	☐
Lupus	☐	☐
Rheumatoid arthritis	☐	☐
Multiple Sclerosis	☐	☐
Celiac Disease	☐	☐
Thyroid disorder	☐	☐
Irritable bowel	☐	☐
Meningitis	☐	☐
Rheumatic fever	☐	☐
Concussion/TBI	☐	☐
How many? ____	☐	☐

	Self	Family Member
Bipolar Disorder	☐	☐
Schizophrenia	☐	☐
Obsessive Compulsive Dis.	☐	☐
Genetic disorder of any kind	☐	☐
Allergies	☐	☐
food	☐	☐
environmental	☐	☐
Dementia (not sure what type)	☐	☐
Alzheimer's Disease	☐	☐
Lewy Body Dementia	☐	☐
Vascular Dementia	☐	☐
Huntington's disease	☐	☐
Other Autoimmune disorder	☐	☐
Bleeding disorder	☐	☐
Other: _____	☐	☐

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 (or attach a list):

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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

SUBSTANCE USE

Do you currently smoke? **Yes** **No**
How much do you smoke per day? ____/packs per day

Are you a former smoker? **Yes** **No**
If yes, when did you quit? _____
How much did you smoke per day? ____/packs per day

Do you use chewing tobacco? **Yes** **No**

Do you currently drink? **Yes** **No**
How many glasses do you drink: ___/per night ___/per week
What is your drink of choice? _____

Was there a time when your use was heavier?	**Yes** **No**
Have you had problems due to your alcohol consumption? (i.e., injuries, legal problems, family conflicts, work problems)	**Yes** **No**
Have you experienced withdrawal symptoms after stopping use of alcohol?	**Yes** **No**
Have you ever had a blackout?	**Yes** **No**
Have you ever been involved in alcohol/drug treatment?	**Yes** **No**
Do you use, or have you ever used, marijuana?	**Yes** **No**
Have you ever used any other drugs?	**Yes** **No**

If yes, please list:

PERSONAL INFORMATION: Where were you born? _____

If outside of the US, at what age did you move here? _____

What was your first language? English Spanish French Other: _____

Were there any problems/complications with your birth? **Yes** **No**
If yes, please describe:

Were there any difficulties with your early development (e.g., walking, talking, toileting, etc)? **Yes** **No**

How many brothers and sisters do you have? _____

How many brothers and sisters do you have who are living? _____

Current Marital Status: Single In a relationship Married Separated Divorced Widowed

If married, how long have you been married? _____
Number of marriages:____
Number of divorces: ____

Do you have children? **No Yes** (how many?: _____) Grandchildren? **No Yes** (how many?) _____

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/did you work? _____

What is/was your job description/title? _____

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 any disability compensation as a result of your illness?	**Yes**	**No**
Are you currently receiving disability compensation for past 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