Glen Wurglitz, M.Div., Psy.D.
3535 E. New York Street - Suite 214
Aurora IL 60504-4465
630-390-8436 [phone] 630-820-4352 [fax]

Neuropsychological History Questionnaire

Confidential

Patient's Name: ____

[Completed by: ________________________ Relationship to Patient: __________________]

Today's Date: __________________

Patient's Date of Birth: ____________________ Current Age: ______

Gender: [ ] Female [ ] Male

Handedness: [ ] Right [ ] Left [ ] Both

Marital Status: [ ] Single [ ] Married [ ] Divorced
[ ] Widowed [ ] Divorced/Remarried

Ethnicity: [ ] Caucasian [ ] Hispanic [ ] African-American
[ ] Asian [ ] Native American [ ] _______________

Address: ____ Day Phone: __________________

City: ___________________ State: ____ Zip: _______ Evening Phone: ______________

Referral Information:

Person who referred
you for testing: ____

Address: ____

____

Phone: ______________________

Fax: ______________________

What is your understanding of why you are undergoing this evaluation? Include all pertinent facts, such as date of injury/illness, what happened, etc.:

____

____

____

____

____

Have you ever had any psychological or neuropsychological testing done before?

[ ] Yes [ ] No

If yes, by whom? ____

____

Date(s): ____

Test(s): ____

Outcome: ____

____

____

Is this case involved in any litigation currently, or do you intend to pursue litigation in the future? **[ ] Yes [ ] No**

If Yes, please describe: ____

____

____

____

____

____

Presenting Problems/Symptoms

Have you ever experienced a head injury with loss of consciousness or sense of being dazed? [ ] Yes [ ] No

If Yes, please describe and provide date of occurrence(s): ____________________

____

____

____

____

Please describe the symptoms or problems that are of most concern to you:

____

____

____

____

Please describe when and how you first became aware of these difficulties and whether they have gotten worse over time:

____

____

____

____

Please list/describe current sources of stress in your life (for example, any losses, major changes of circumstances, financial/interpersonal/job pressures, etc.):

____

____

____

____

Medical History

Please list all of your current medications below:

Medication	Amount/Frequency	Reason

Please list all illnesses, surgeries, and hospitalizations you have experienced:

Illness/Condition	*Dates*	*Treatment*

Please list any neurological tests such as MRIs, CTs, spinal taps, EEGs, etc., including dates and hospitals:

Test (Hospital)	*Dates*	*Results*

Medical History (continued)

Please check any of the following that you have ever experienced, and briefly describe (including dates/frequency):

[ ] Seizures ______________________________
[ ] Loss of sensation in any part of your body ______________________________
[ ] Paralysis or weakness in any part of your body ______________________________
[ ] Loss of change in sense of smell ______________________________
[ ] Loss of hearing ______________________________
[ ] Loss of vision ______________________________
[ ] Change in sense of taste ______________________________
[ ] Dizziness or fainting spells ______________________________
[ ] High Blood Pressure ______________________________
[ ] Hallucinations (auditory or visual) ______________________________
[ ] Exposure to toxic chemicals ______________________________
[ ] Electric Shock ______________________________

Please indicate below if anyone in your family has had the following conditions by checking the box and putting their relationship to you in the space(s) provided:

[ ] Diabetes ______________ ______________
[ ] Hypertension ______________ ______________
[ ] Heart Disease ______________ ______________
[ ] Stroke ______________ ______________
[ ] Cancer ______________ ______________
[ ] Epilepsy ______________ ______________
[ ] Multiple Sclerosis ______________ ______________
[ ] Parkinson's ______________ ______________
[ ] Alzheimer's ______________ ______________
[ ] Alcoholism ______________ ______________

Please describe any other relevant family medical history: ______________

____

____

Please list any known allergies: ______________________________

____

Substance Use

Do you now or have you ever regularly used tobacco products? [ ] Yes [ ] No

If yes, please describe including frequency, how long, etc.: ______________________

____

____

Do you now or did you ever drink beer/alcoholic products? [ ] Yes [ ] No

Type	*Frequency*	*Quantity*	*Age 1st Used*

If you are no longer drinking, what is the reason(s) you stopped? ____________

____

____

In your opinion, is your drinking a problem? [ ] Yes [ ] No

Have others ever told you your drinking is a problem? [ ] Yes [ ] No

Have you ever had legal difficulties related to drinking? [ ] Yes [ ] No

If yes, please describe/explain: ____

____

____

Have you ever had work difficulties related to drinking? [ ] Yes [ ] No

If yes, please describe/explain: ____

____

Have you ever been treated for alcohol abuse? [ ] Yes [ ] No

If yes, please describe/explain: ____

____

Substance Use (continued)

Do you now or have you ever regularly used illicit or "street" drugs (for example, marijuana, cocaine, heroin, LSD, etc.)? [ ] Yes [ ] No

If yes, please describe including frequency, how long, etc.: ________________

____

____

____

____

Have you ever been treated for drug abuse or dependence? [ ] Yes [ ] No

If yes, please describe/explain and give dates of treatment: ________________

____

____

____

In your opinion, is your drug use a problem? [ ] Yes [ ] No

Have others ever told you your drug use is a problem? [ ] Yes [ ] No

Have you ever had legal difficulties related to drug use? [ ] Yes [ ] No

If yes, please describe/explain: ________________________________

____

____

Have you ever had work difficulties related to drug use? [ ] Yes [ ] No

If yes, please describe/explain: ________________________________

____

____

____

Psychiatric History

Please describe your psychiatric history form the time of your first symptom to the present: ______________________________

____

____

____

____

Please provide names and dates of all psychiatric/psychological treatments and any hospitalizations:

Clinician or Hospital	*Dates*	*Problem or Treatment*

Please indicate if anyone in your family has had the following by checking the box and putting their relationship to you in the space provided:

[ ] Depression ______________ ______________
[ ] Schizophrenia ______________ ______________
[ ] Anxiety/Panic ______________ ______________
[ ] Attention Deficit ______________ ______________
[ ] Bipolar ______________ ______________
[ ] ____________ ______________ ______________
[ ] ____________ ______________ ______________

Please describe any other family history of psychiatric problems: ______________

____

____

____

____

Developmental History

Did your mother ever smoke, take drugs or use alcohol during pregnancy?

[ ] Yes [ ] No

Were there any problems during the pregnancy or delivery?

[ ] Yes [ ] No

If yes, please describe: ______________________________

____

____

Please check each of the following conditions that describe behaviors or emotions that you experienced *as a child*, and briefly describe:

[ ] Delay learning to walk ____________
[ ] Delay learning to talk ____________
[ ] Delay learning to read ____________
[ ] Behavior problems at home ____________
[ ] Behavior problems at school ____________
[ ] Bedwetting ____________
[ ] Nail biting ____________
[ ] Difficulty paying attention ____________
[ ] Difficulty making friends ____________
[ ] Depressed ____________
[ ] Difficulty controlling emotions ____________
[ ] Daydream often ____________
[ ] Easily distracted ____________
[ ] Trouble sitting still ____________
[ ] Difficulty finishing projects ____________
[ ] Attention wanders ____________
[ ] Cried easily/often ____________
[ ] Speech/language problems ____________
[ ] Acted young for age ____________
[ ] Frustrated easily ____________
[ ] Excitable ____________
[ ] Stubborn ____________
[ ] Poor coordination ____________
[ ] Hyperactive ____________
[ ] Blank/staring spells ____________
[ ] Memory problems ____________
[ ] Impulsivity ____________
[ ] Disorganized ____________
[ ] Aggressiveness ____________
[ ] Timid/shy ____________
[ ] Tantrums ____________
[ ] Nightmares ____________
[ ] Poor self esteem ____________
[ ] Unpredictable ____________
[ ] Fidgety ____________
[ ] Alcohol/drug use ____________

Additional information about any childhood problems: ____________

____

____

____

Educational History

Please summarize your educational history below:

School Attended	*City/St.*	*Dates*	*Grades /Degree*	*Your Avg. Grades*

Is English your primary language? [ ] Yes [ ] No

If no, list all languages spoken in order of fluency: ____________________

____

Did you have difficulty with any school subjects? [ ] Yes [ ] No

If yes, list which ones: ____________________

____

Did you ever have any special tutoring or counseling? [ ] Yes [ ] No

If yes, explain: ____________________

____

____

Did you ever repeat any grades: [ ] Yes [ ] No

If yes, which ones: ____________________

____

Were you ever in any special education classes in school? [ ] Yes [ ] No

If yes, explain: ____________________

____

____

Occupational History

Please summarize your occupational history below:

Position	*Place*	*Dates*	*Reason for Leaving*

Have you ever been on unemployment, disability or worker's compensation?

[ ] Yes [ ] No

If yes, explain (include dates and reason for claim: ______________________

____

____

Please list any special talents, interests or hobbies: ______________________

____

Have you had any arrests or legal problems? [ ] Yes [ ] No

If yes, explain (include dates and nature of the violations:______________

____

____

Your current occupational status:

[ ] Full time [ ] Part time [ ] Unemployed

[ ] Retired [ ] Disability [ ] Volunteer

If currently employed, please list your job title and description of the type of work you do, including your responsibilities and the nature of your work. Be as explicit as possible: ____

____

____

Social/Functional History

Do you live alone? [ ] Yes [ ] No

Where were you born? ______________________________

Please list all the members of your family of origin (parents and siblings)

Name	*Age*	*Relationship to you*	*Current health*

Please list all the members of your current immediate family (spouse & children)

Name	*Age*	*Relationship to you*	*Current health*

Please check any of the following activities of daily living that you cannot now do or have difficulty completing independently, and briefly describe:

[ ] Getting dressed ______________________________
[ ] Bathing or showering ______________________________
[ ] Taking medications ______________________________
[ ] Cooking ______________________________
[ ] Cleaning ______________________________
[ ] Driving ______________________________
[ ] Money management ______________________________
[ ] Keeping Appts. ______________________________
[ ] Shopping ______________________________