BACKGROUND QUESTIONNAIRE – ADULT

The following is a detailed questionnaire on your development, medical history and current functioning at home and at work. This information will be integrated with the rest of your evaluation in order to provide a better picture of your abilities as well as any problem areas. ***Please fill out this questionnaire as completely as you can.***

Name of Person completing this form (if not client): _____

Relationship to client: _____

Client's Name: _____ Today's Date: _____

Date of Birth _____ Age _____ Sex: Male ☐ Female ☐

Primary Language _____Secondary Language _____ Fluent / Non-Fluent (circle one)

Religion/Spiritual Belief: _____ Race/Ethnicity: _____

Handedness: ☐ Right ☐ Left ☐ Other (e.g., ambidextrous, mixed dominance)

Who referred you for this evaluation? _____

Briefly describe problem: _____

_____

_____

Date of the onset of symptoms:_____

Overall, my symptoms have developed: ☐ Slowly ☐ Quickly ☐ Suddenly

My symptoms occur: ☐ Occasionally ☐ Often ☐ Constantly

Over the past 6 months, my symptoms have: ☐ Improved ☐ Stayed same ☐ Worsened

Is there anything you can do (or someone does) that gets the problems to stop or be less intense, less frequent, or shorter?

_____

_____

What seems to make the problems worse? _____

_____

In summary, there is ☐ Definitely something wrong with me ☐ Possibly something wrong with me

☐ Nothing wrong with me

Are there specific questions would you like answered by this evaluation?_____

_____

_____

_____

_____

_____

_____

CURRENT COMPLAINTS

For each symptom that applies, place a check mark in the box. Add any comments as needed.

Motor

- ☐ Excessive fatigue
- ☐ Nausea or vomiting
- ☐ Urinary incontinence
- ☐ Bowel problems
- ☐ Weakness
- ☐ Problems with fine motor control
- ☐ Tremor or shakiness
- ☐ Tics or strange movements
- ☐ Balance Problems
- ☐ Often bump into things
- ☐ Blackout spells (fainting)

Sensory

- ☐ Headaches
- ☐ Loss of feeling / numbness
- ☐ Tingling or strange skin Sensations
- ☐ Difficulty telling hot from cold
- ☐ Dizziness
- ☐ Visual Impairment
- ☐ Wear glasses/Contacts
- ☐ Problems seeing on one side
- ☐ Sensitivity to bright lights
- ☐ Blurred vision
- ☐ See things that are not there
- ☐ Brief periods of blindness
- ☐ Need to squint or move closer to see clearly
- ☐ Hearing loss
- ☐ Wear hearing aid
- ☐ Ringing in ears
- ☐ Hear strange sounds
- ☐ Unaware of things on one side of my body
- ☐ Problems with taste
- ☐ Problems with smell
- ☐ Pain (describe):_____

_____

_____

_____

Problem Solving

- ☐ Difficulty figuring out how to do things
- ☐ Difficulty figuring out problems most can do
- ☐ Difficulty planning ahead
- ☐ Difficulty changing a plan or activity
- ☐ Difficulty thinking as quickly as needed
- ☐ Difficulty completing activities on time
- ☐ Difficulty doing things in the right order

Language and Math Skills

- ☐ Difficulty finding the right word
- ☐ Slurred speech
- ☐ Odd or unusual speech sounds
- ☐ Difficulty expressing thoughts
- ☐ Difficulty understanding what others say
- ☐ Difficulty understanding what I read
- ☐ Difficulty writing letters or words
- ☐ Difficulty with math (e.g., balancing checkbook, making change, etc.)

Nonverbal Skills

- ☐ Difficulty telling right from left
- ☐ Difficulty drawing or copying
- ☐ Difficulty dressing
- ☐ Difficulty with care (e.g., brushing teeth/hair)
- ☐ Problems finding way around familiar places
- ☐ Difficulty recognizing objects or people
- ☐ Decline in my musical abilities
- ☐ Not aware of time (e.g., day, season, year)
- ☐ Slow reaction time
- ☐ Parts of my body do not seem as if they belong to me

Awareness and Concentration

- ☐ Highly distractible
- ☐ Lose my train of thought easily
- ☐ My mind goes blank a lot
- ☐ Difficulty doing more than one thing at a time
- ☐ Become easily confused and disoriented
- ☐ Aura (strange feelings)
- ☐ Don't feel very alert or aware of things
- ☐ Tasks require more effort or attention

Memory

- ☐ Forget where I leave
- ☐ Forget Names
- ☐ Forget what I should be doing
- ☐ Forget where I am or where I am going
- ☐ Forget recent events (e.g., breakfast)
- ☐ Forget facts but can remember how to do things
- ☐ Forget faces of people I know (when not present)
- ☐ Forget appointments
- ☐ Forget events that happened long ago
- ☐ More reliant on others to remind me of things
- ☐ More reliant on notes to remember things
- ☐ Forget the order of events

Mood / Behavior / Personality

		(Rate Severity) Mild	Moderate	Severe	Date of Onset
☐	Sadness or depression	☐	☐	☐	_____
☐	Anxiety or nervousness	☐	☐	☐	_____
☐	Stress	☐	☐	☐	_____
☐	Sleep Problems (falling asleep ☐ staying asleep ☐)				_____
☐	Experience nightmares on a daily / weekly basis				_____
☐	Become angry more easily	☐	☐	☐	_____
☐	Euphoria (feeling on top of the world)	☐	☐	☐	_____
☐	Much more emotional (e.g., cry more easily)	☐	☐	☐	_____
☐	Feel as if I just don't care anymore	☐	☐	☐	_____
☐	Easily frustrated	☐	☐	☐	_____
☐	Doing things automatically (without awareness)	☐	☐	☐	_____
☐	Less inhibited (do things I would not do before)	☐	☐	☐	_____
☐	Difficulty being spontaneous	☐	☐	☐	_____
☐	Change in energy (☐ loss ☐ increase)	☐	☐	☐	_____
☐	Change in appetite (☐ loss ☐ increase)	☐	☐	☐	_____
☐	Change in weight (☐ loss ☐ increase)	☐	☐	☐	_____
☐	Change in sexual interest (☐ increase ☐ decline)				_____
☐	Lack of interest in pleasurable activities	☐	☐	☐	_____
☐	Increase in irritability	☐	☐	☐	_____
☐	Increase in aggression	☐	☐	☐	_____
☐	Seeing things that no one else can see	☐	☐	☐	_____
☐	Hearing things that no one else can hear	☐	☐	☐	_____
☐	Agitation / Feeling restless	☐	☐	☐	_____
☐	Suicidal thoughts (☐ plan ☐ intent ☐ attempt)				_____

Other changes in mood or personality or in how you deal with people_____

_____

Have others commented to you about changes in your thinking, behavior, personality, or mood? If yes, who and what have they said? ☐ Yes ☐ No

_____

_____

Are you experiencing any problems in the following aspects of your life? If so, please explain:

Marital / Family _____

_____

Financial / Legal _____

_____

Housekeeping / Money Management _____

_____

Driving _____

Last driving accident or traffic violation_____

Self-Care (bathing, grooming, dressing)_____

_____

MEDICAL HISTORY

☐	Head injuries	☐	Meningitis
☐	Loss of consciousness	☐	Oxygen deprivation
☐	Motor vehicle accidents	☐	Diabetes
☐	Major falls, sports accidents, or Work injuries	☐	Heart disease
☐	Seizures	☐	Cancer
☐	Stroke	☐	Back or neck injury
☐	Arteriosclerosis	☐	Poisoning
☐	Dementia	☐	Exposure toxins

Medical Diagnosis (if any): _____

_____

_____

Date of last vision exam: _____ Date of last hearing exam: _____

Are you currently taking any medication?

Name Reason for taking Dosage Date Started

_____

_____

_____

_____

_____

_____

_____

Are you currently in counseling or under psychiatric care? ☐ Yes ☐ No

Please provide the following information for any past therapy or counseling

Name of Professional Reason for Treatment Date Started Date Ended

_____

_____

_____

_____

Please list all inpatient hospitalizations including the name of the hospital, date of hospitalization, duration, and diagnosis:

_____

_____

_____

SUBSTANCE USE HISTORY

I drink alcohol: ☐ rarely or never ☐ 1-2 days/week ☐ 3-5 days/week ☐ daily

I started drinking at age: ☐ Less than 10 ☐ 10-15 ☐ 16-19 ☐ 20-21 ☐ Over 21

I used to drink alcohol but stopped: ☐ Yes ☐ No Date Stopped: _____

My last drink was: ☐ Less than 24 hours ago ☐ 24-48 hours ago ☐ Over 48 hours ago

Preferred type(s) of drinks: _____

Usual number of drinks I have at one time: _____

Check all that apply:

☐ I can drink more than most people my age and size before I get drunk.

☐ I sometimes get into trouble (fights, arrests, work problems, conflicts with family, etc.) after drinking (specify):

_____

_____

☐ I sometimes black out after drinking.

Please check all the drugs you are now using or have used in the past:

	Presently using	Used in the past
Amphetamines (including diet pills)	☐	☐
Barbiturates (downers, etc.)	☐	☐
Cocaine or crack	☐	☐
Hallucinogenic (LSD, acid STP, etc.)	☐	☐
Inhalants (glue, nitrous oxide, etc.)	☐	☐
Marijuana	☐	☐
Opiate narcotics (heroin, morphine, etc.)	☐	☐
PCP (or angel dust)	☐	☐
Others (list)	☐	☐

Do you consider yourself dependent on any of the above drugs? ☐ Yes ☐ No
If yes, which one(s): _____

Do you consider yourself dependent on any prescription drugs? ☐ Yes ☐ No
If yes, which one(s): _____

Check all that apply:

☐ I have gone through drug withdrawal.
☐ I have used IV drugs.
☐ I have been in drug treatment.

Has use of drugs ever affected your work performance? ☐ Yes ☐ No

Has use of drugs or alcohol ever affected your driving ability? ☐ Yes ☐ No

Do you smoke ☐ Yes ☐ No (if yes, amount per day: _____)

Do you drink coffee ☐ Yes ☐ No (if yes, amount per day: _____)

FAMILY HISTORY

The following questions deal with your biological mother, father, brothers, and sisters:

Is your mother alive? ☐ Yes ☐ No
If deceased, what was the cause of her death?_____

Mother's highest level of education: _____

Mother's Occupation: _____

Does your mother have a known or suspected learning disability? ☐ Yes ☐ No
If yes, describe: _____

_____

Is your father alive? ☐ Yes ☐ No
If deceased, what was the cause of his death? _____

Father's highest level of education: _____

Father's Occupation: _____

Does your father have a known or suspected learning disability? ☐ Yes ☐ No
If yes, describe: _____

_____

How many brothers and sisters do you have? _____

What are their ages? _____

Are there any unusual problems (physical, academic, psychological) associated with any of your brothers or sisters?
☐ Yes ☐ No If yes, describe: _____

Please check all problems that exist(ed) in close biological family members (parents, brothers, sisters, grandparents, aunts, uncles). Note who it is (was).

		Who?
Neurologic disease		
☐	Alzheimer's disease or senility?	_____
☐	Huntington's disease	_____
☐	Multiple sclerosis	_____
☐	Parkinson's disease	_____
☐	Epilepsy or seizures	_____
☐	Other neurologic disease	_____
Psychiatric illness		
☐	Depression	_____
☐	Anxiety	_____
☐	Bipolar illness (manic-depression)	_____
☐	Schizophrenia	_____
☐	Suicide	_____
Other disorders		
☐	Mental retardation	_____
☐	Speech or language disorder	_____
☐	Learning problems	_____
☐	Attention problems	_____
☐	Behavior problems	_____
☐	Other major disease or disorder	_____

_____

SOCIAL HISTORY

Marital History
Current marital status: ☐ Never Married ☐ Married ☐ Living with Partner
☐ Separated ☐ Divorced ☐ Widowed

Years married to current spouse: _____

Dates of previous marriages: From _____ to _____
From _____ to _____

Spouse's Name: _____ Age: _____

Spouse's Occupation: _____

Spouse's Health: ☐ Excellent ☐ Good ☐ Poor

Children (include stepchildren)
Name Age Gender Occupation

_____

_____

_____

_____

_____

_____

Who currently lives at home? _____

Do any family members have any significant health concerns/ special needs? _____

_____

How would you describe your social network? ☐ Stable ☐ Unstable ☐ Large ☐ Small

What social activities to you participate in? Clubs/ Groups/ Church? _____

_____

_____

_____

_____

DEVELOPMENTAL HISTORY

You were born: ☐ on time ☐ prematurely ☐ late

Your weight at birth: _____

Where were you born: _____

Were there any problems associated with your birth (e.g., oxygen deprivation, unusual birth position, etc.) or the period afterward (e.g., need for oxygen, convulsions, illness, etc.)? ☐ Yes ☐ No

Describe: _____

Check all that applied to your mother while she was pregnant with you:

- ☐ Accident
- ☐ Alcohol Use
- ☐ Cigarette smoking
- ☐ Drug use (marijuana, cocaine, LSD, etc.)
- ☐ Illness (toxemia, diabetes, high blood pressure, infection, etc.)
- ☐ Poor nutrition
- ☐ Psychological problems
- ☐ Medications (prescribed or over the counter) taken during pregnancy
- ☐ Other Problems: _____

Rate your developmental progress as it has been reported to you, by checking one description for each area:

	Early	Average	Late
Walking	☐	☐	☐
Language	☐	☐	☐
Toilet Training	☐	☐	☐
Overall Development	☐	☐	☐

As a child, did you have any of these conditions?

- ☐ Attention problems
- ☐ Clumsiness
- ☐ Developmental delay
- ☐ Hyperactivity
- ☐ Muscle weakness
- ☐ Learning disability
- ☐ Speech problems
- ☐ Hearing problems
- ☐ Frequent ear infections
- ☐ Visual problems

Where were you raised? _____

Did you parents divorce? If so how old were you when they separated? _____

Did you have a positive relationship with your Mother? _____ Father? _____

Have you ever been: Sexually Abused ☐ Yes ☐ No

Physically Abused ☐ Yes ☐ No

Emotionally Abused ☐ Yes ☐ No

EDUCATIONAL HISTORY

	Name of School	Grades and Degree certifications	Years Attended
Elementary			
High School			
Trade School			
College/ University			

If a high school diploma was not awarded, did you complete a GED? ☐ Yes ☐ No ☐ N/A

Were any grades repeated? ☐ Yes ☐ No

Reason: _____

Where there any special problems learning to read, write, or do math? _____

_____

Were you ever in any special class (es) or did you ever receive special services? ☐ Yes ☐ No

If yes, what grade(s) _____ or age? _____

What type of class? _____

How would you describe your usual performance as a student?

☐ A & B
☐ B & C
☐ C& D
☐ D & F

Provide any additional helpful comments about your academic performance:_____
_____
_____
_____

MILITARY SERVICE

Did you serve in the military? ☐ Yes ☐ No
If yes, what branch? _____ Dates: _____

Ranks and honors:_____

Did you serve in combat areas? _____ If so, what arena? _____

Did you receive injuries or were you ever exposed to any dangerous or unusual substances during your service?

☐ Yes ☐ No
If yes, explain: _____

Do you have any continuing problems related to your military service? Describe:

_____

_____

OCCUPATIONAL HISTORY

Are you currently ☐ employed ☐ unemployed ☐ retired ☐ disabled

Current job title: _____

Name of employer: _____

Current responsibilities: _____

Dates of employment: _____

Are you currently experiencing any problems at work? ☐ Yes ☐ No

If yes, describe: _____

_____

Do you see your current work situation as stable? ☐ Yes ☐ No

Approximate annual income: _____

Previous Employers:

Name	Dates	Duties/Position	Reason for Leaving

LEGAL HISTORY

Have you ever been arrested? ☐ Yes ☐ No
Describe: _____

_____

_____

RECREATION

Briefly list the types of recreations (e.g., sports, games, TV, hobbies, etc.) that you enjoy:

_____

_____

_____

Are you still able to do these activities?

_____

Have you had a prior psychological or neuropsychological exam? ☐ Yes ☐ No

If yes, complete the following:

Name of psychologist: _____

Date: _____

Reason for evaluation: _____

Finding of evaluation: _____

Please provide any additional information that you feel is relevant:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____