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BIOGRAPHICAL QUESTIONNAIRE

Please provide the following information as completely as possible. These questions are important to the evaluation and will help us to use our time together efficiently. If you have not completed this form online **PLEASE BRING THE COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT.**

I. DEMOGRAPHIC INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ MR#: _____

Who referred you here? _____

What is your understanding of the reason you are here?

_____

_____

Place of Birth: _____ If not in the US, at what age did you immigrate? _____

Primary Language: _____ If not English, at what age did you learn English? _____

How long have you lived in your present area? _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

If remarried, please indicate the number of previous marriages: _____

Handedness: ◯ Right ◯ Left ◯ Ambidextrous

If you have children, please list their names, ages, and any health problems:

	Name	Age	Health Problems
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Were you raised by your biological parents? ◯Yes ◯No

If no, who raised you? _____

	Years of Education	Occupation
Your father:	_____	_____
Your mother:	_____	_____

II. EDUCATION

How many years of school did you complete? _____

List any degrees you have obtained: _____

	SCHOOL		Years	Date of	Grade Point
	Name	City	Completed	Graduation	Average
High School	_____	_____	_____	_____	_____
Associates	_____	_____	_____	_____	_____
Bachelors	_____	_____	_____	_____	_____
Masters	_____	_____	_____	_____	_____
Doctorate	_____	_____	_____	_____	_____
Trade School	_____	_____	_____	_____	_____

Have you ever been diagnosed with a learning disability? ◯Yes ◯No

If so, who made the diagnosis and when? _____

Were you ever in any special education classes or require tutoring? ◯Yes ◯No

If so, what classes and when? _____

Have you ever repeated or skipped a grade? ◯Yes ◯No

If so, what grade(s)? _____ ◯Repeated ◯Skipped

Please list your STRONG subjects in school: _____

Please list your WEAK subjects in school: _____

III. EMPLOYMENT HISTORY

List your employment history [*if additional space is needed, please include separate sheet*]:

Current/most recent position title: _____

Name of employer: _____ Dates of employment: _____

Job responsibilities: _____

Reason for leaving: _____

Previous position title: _____

Name of employer: _____ Dates of employment: _____

Job responsibilities: _____

Reason for leaving: _____

Previous position title: _____

Name of employer: _____ Dates of employment: _____

Job responsibilities: _____

Reason for leaving: _____

Previous position title: _____

Name of employer: _____ Dates of employment: _____

Job responsibilities: _____

Reason for leaving: _____

IV. MILITARY HISTORY

If you have any military history, please specify below:

Branch: _____ Dates of service: _____ Highest Rank: _____

Honorable discharge? ◯Yes ◯No If no, please explain: _____

Types of duties performed: _____

V. MEDICAL HISTORY

Did you walk and talk at expected ages? ◯ Yes ◯ No ◯ Don't know

List all current health problems (e.g., injury, high blood pressure, diabetes, high cholesterol)

_____
_____
_____

Have you ever had any serious medical conditions or trauma? (Check all that apply)

☐ Meningitis ☐ Encephalitis ☐ Seizures ☐ Loss of Consciousness

☐ High Voltage Electrical Shock ☐ Toxic Chemical Exposure ☐ High Fever ☐ Head Injury

Other(s): _____

If yes, please describe:

_____
_____

List all **medical hospitalizations**, starting with the most recent:

Dates	Diagnosis/Condition	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all **current medications** and dosage (you may bring a list to your appointment):

Medication	Dosage	How often?	Why do you take this?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you manage your medications independently (e.g., organizing pills, ordering refills)? ◯ Yes ◯ No

Do you take your medications independently? ◯ Yes ◯ No

Do you have any problems with your vision? ◯ Yes ◯ No

If so, are these problems corrected with lenses? ◯ Yes ◯ No

Do you have any problems with your hearing? ◯ Yes ◯ No

If so, are these problems corrected with hearing aids? ◯ Yes ◯ No

VI. FAMILY MEDICAL HISTORY

Please describe your parents' state of health, listing any known health problems for each.

Mother: _____

Father: _____

Are you aware of any history of neurological or cardiovascular conditions in your immediate family and relatives (including aunts, uncles, grandparents, and first cousins)? **This would include conditions such as strokes, epilepsy, Alzheimer's disease, Parkinson's disease, Huntington's disease, Multiple Sclerosis, heart attacks, high blood pressure, diabetes, etc…** If so, please describe:

_____

_____

_____

Please indicate any deceased relatives, ages, year of death, and cause of death.

Family Member	Age and Year of Death	Cause of Death
Mother		
Father		
Siblings:		

VII. SUBSTANCE USE HISTORY

Substance	CURRENT		PAST		
	Amt per Week	For How Long?	Amt per Week	When?	For How Long?
Tobacco					
Beer					
Wine					
Liquor					
Marijuana					
Cocaine					
Heroin					
Other					
Other					

VIII. PSYCHIATRIC HISTORY

Are you currently receiving mental health services or counseling? ◯ Yes ◯ No

Have you ever received mental health services or counseling? ◯ Yes ◯ No

If yes, please list date(s), type of service (e.g., evaluation, therapy, medication), and provider.

Date(s)	Type of Service	Provider (Name & Location)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized for a psychiatric or mental disorder? ◯ Yes ◯ No

If yes, please specify:

Year:	Length of Stay:	Location:	Diagnosis:	Treatment:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you **currently** prescribed any psychiatric medications (e.g., for anxiety, depression, mood, etc.)? If yes, please specify: ◯ Yes ◯ No

Medication	Dosage	How often?	Why do you take this?

(Please use the back of this page if there are additional medications)

Please list any psychiatric medications you have been prescribed **in the past**.

Medication	When	Duration of use

Prior psychological/neuropsychological assessments? ◯ Yes ◯ No

If yes, please list date(s),reason, and provider/location.

Date(s)	Reason	Provider (Name & Location)

Do you know of any history of psychiatric conditions or mental illness in any family members or relatives? **This would include conditions such as alcoholism, depression, manic-depression, bipolar disorder, anxiety, schizophrenia, "nervous breakdown", etc.** If so, please describe…

Family Member	Condition/Mental Illness

IX. LEGAL HISTORY

Have you ever been convicted of a felony? ◯ Yes ◯ No If yes, please specify:

Date	Type of Offense
_____	_____
_____	_____

Have you ever been convicted of DUI (alcohol or drugs)? ◯ Yes ◯ No If yes, please specify:

Date	Type of Offense
_____	_____
_____	_____

Are you currently being represented in a workers' compensation claim? ◯ Yes ◯ No

Are you currently involved in any other type of legal action related to your injury (e.g., personal injury lawsuit)? ◯ Yes ◯ No

X. CURRENT PROBLEMS

In your own words, please describe your main concern or problem:

_____

_____

Do you notice any difficulties with your ability to think, remember, concentrate, use language, or deal with spatial problems? ◯ Yes ◯ No If yes, please describe:

_____

_____

Please check any of the following problems that apply:

Attention/Concentration

- ☐ Becoming tired easily
- ☐ Having difficulty concentrating
- ☐ Becoming confused easily

Memory

- ☐ Recalling things that have happened to you in the past
- ☐ Recalling things that have been recently been told to you
- ☐ Recalling people's names

- [ ] Recalling where you have left things
- [ ] Recalling how to get places

Language

- [ ] Understanding what is said to you
- [ ] Comprehending what you read
- [ ] Speaking clearly
- [ ] Speaking more slowly
- [ ] Finding the correct words/names for things
- [ ] Writing legibly
- [ ] Spelling correctly

Emotional Problems

- [ ] Tension or anxiety
- [ ] Depression or sadness
- [ ] Mood swings
- [ ] Anger control problems
- [ ] Lack of feelings
- [ ] Lack of motivation
- [ ] Feeling overly energetic/manic
- [ ] Nightmares
- [ ] Thoughts of suicide
- [ ] Hallucinations

Practical Problems

- [ ] Managing money, including handling finances, checkbook, etc.
- [ ] Keeping appointments
- [ ] Changes in ability to handle household chores
- [ ] Changes in driving ability (e.g., getting lost; confusion with directions; accidents; tickets)
- [ ] Ability to do math or spell
- [ ] Changes in the way you relate to/get along with family, friends, etc.

Physical Issues

- [ ] Problems with coordination
- [ ] Weakness
- [ ] Numbness
- [ ] Clumsiness
- [ ] Dizziness
- [ ] Visual problems not corrected by glasses
- [ ] Hearing problems
- [ ] Problems with taste or smell
- [ ] Bladder or bowel control problems
- [ ] Balance problems
- [ ] Changes in weight
- [ ] Changes in sleep
- [ ] Seizures
- [ ] Fainting spells

- [ ] Other: _____

Any trouble falling asleep? ◯ Yes ◯ No

Any trouble staying asleep? ◯ Yes ◯ No

Any trouble waking up early? ◯ Yes ◯ No

How has your appetite been recently? _____

Is your weight stable? ◯ Yes ◯ No

List any current/past hobbies:

_____
_____
_____

Describe your typical day:

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____

PLEASE BE SURE TO COMPLETE QUESTIONNAIRE PRIOR TO YOUR SCHEDULED APPOINTMENT

Submit