NEUROPSYCHOLOGICAL ASSOCIATES, LLC

Edward J. Barnoski, PhD., ABPP/ABCN
77 Medford Avenue, Suite D
Patchogue, NY 11772
(631) 366-3369
Fax: (631) 366-2043

History Questionnaire

Instructions: Please fill out this form to help the psychologist learn useful information about you that would assist the evaluation or treatment process. **Please provide <u>all</u> the information requested.** Be assured that all information given on this form, as well as in treatment, is considered confidential and treated with respect and in a manner consistent with the privacy rules of the Health Insurance Portability and Accessibility Act (HIPAA). Please return this at the first visit if it was sent to you in advance.

PERSONAL INFORMATION:

Name: (Full name) _____
Home Address: _____
_____
Phone Number: Home: _____ Work: _____
(With area code)
Cell: _____ E-mail address: _____ ok to use: Y or N
Age: _____ Date of Birth: _____ Sex: Male____ Female _____
Handedness: Right _____ Left _____
Marital Status: (check one) Single ____ Married _____ Divorced _____ Separated _____
Other ____ ()

REFERRAL INFORMATION:

Who referred you? _____

PLEASE DESCRIBE, IN YOUR WORDS, WHY YOU ARE HERE:

_____
_____
_____
_____

Please describe your overall health:

_____

Name (s) of Primary AND other treating doctors:
Name: _____
Address_____
Phone #: _____

Name: _____
Address: _____
Phone #: _____

Name: _____
Address: _____
Phone #: _____

In the past year, have you had any significant medical or physical problem that is affecting you now? YES_____ NO_____ Please describe:

_____

Have you ever had:		**If so, list date (s):**
Head injury/traumatic brain injury	Yes_____ No_____	_____
Stroke/CVA/Aneurysm	Yes_____ No_____	_____
Other brain injury/illness	Yes_____ No_____	_____
(If so, what condition? _____		
Seizures/epilepsy	Yes_____ No_____	_____
Heart Attack	Yes_____ No_____	_____
Diabetes	Yes_____ No_____	_____
Surgery	Yes_____ No_____	_____
Other major illness or medical condition	Yes_____ No_____	_____

Please explain any that you checked yes to:

_____

_____

Were you ever unconscious or in a coma? Yes____ No____ If so, when & for how long?

_____

<u>Have you had or do you now have:</u> (CHECK AS APPROPRIATE)

Learning Disabilities?	Yes_____ No_____
Alcohol or drug treatment?	Yes_____ No____
Psychiatric/psychological treatment?	Yes_____ No_____
Individual or Family Therapy	Yes_____ No_____

If yes, please explain: _____

MEDICATION & HERBAL SUPPLEMENTS:

Please list what medications, if any, that you are currently taking:

Name of Medicine	Prescribing MD	Dosage:	What is it taken for?

MEDICAL OR PSYCHOLOGICAL TESTING

PSYCHOLOGICAL: Have you ever had psychological testing before? Yes_____ No_____
Have you had *Neuropsychological* testing before? Yes_____ No_____
If yes, please give details (where, when, results):
_____
_____

MEDICAL TESTS:

Have you ever had an MRI or CT scan of the head? Yes _____ No_____ If so, when? _____
What were the results? _____

Have you ever had an EEG (brain wave scan)? Yes_____ No_____
If so, when and what results were found:
_____
Any other significant medical testing? Yes_____ No_____ If yes, of what and what were the results: _____

ALCOHOL AND DRUG USE

How often do you drink alcoholic beverages: (circle answer below)

Rarely or never 1-2 times a month 3-4 times a month
Every week Several times a week every day or almost every day

Do you think you have a drinking problem? Yes_____ No_____
Have you ever been treated for alcoholism? Yes_____ No_____
12 Step groups like AA: Have you attended? Yes_____ No_____ Now or in the past?
Other 12 Step groups? Is so, which one (s): _____

Do you use any recreational drugs or prescription medications that are not prescribed to you? Yes _____ No _____

If yes, how often: please circle
Rarely or never 1-2 times a month 3-4 times a month
Every week Several times a week every day or almost every day

Please circle any of the following recreational drugs that you use or have used in the past:

Marijuana	Cocaine	LSD	Amphetamines
Heroin	Quaaludes	Crack Cocaine	Other: _____

Smoking: Do you now smoke cigarettes? Yes_____ No_____
How often/how many a day? _____ Since when? _____
If you smoked in the past, when did you quit? _____

FAMILY HISTORY

What is your mother's name? _____ Is she still living? _____
If deceased, when? _____ Cause? _____
What is your father's name? _____ Is he still living? _____
If deceased, when? _____ Cause? _____
Brothers or sisters? Please list names and ages: _____
Spouse's name & age _____ how long married/together? _____
Do you have any children? _____ If so, please list their names and ages:
_____
With whom do you live now? _____
If divorced, separated or widowed, how long? _____
Married how long prior to change? _____

Is there a *family* history of: (check any that apply and write details here)
_____ Mental retardation _____ Neurological problems (stroke, etc)

_____ Learning Disabilities _____ Psychiatric/psychological problems

SCHOOL AND WORK HISTORY

Education

What is the highest grade or academic level you completed? (Check one):

_____ some high school (last grade finished: _____; what year did you leave school? _____)

_____ High School Graduate (year? _____)

_____ Vocational - tech or trade school (what trade/skills? _____)

_____ Some College (estimated # of credits obtained: _____)

_____ College degree: _____ Associate's _____Bachelor's (what was your major? _____)

_____ Post college: _____Some grad school _____Master's _____Post Master's
(Details of post college academic work)
_____

Did you like school? _____ what was your average in school? _____
Do you hope to resume or continue your education? _____
In what area (s)? _____

Work *Are you working now? _____Yes _____ No*

What is your current or most recent occupation? _____
How long at this job? _____ Reason for leaving? _____
Name, address of your employer _____
Do you/did you enjoy your work? _____Yes _____No What did you like about it?
_____
What other jobs have you had in the past?
_____
If you aren't working now, do you want to return to work? _____
Do you think you will have any difficulties returning to work (if your are NOT working now)? If so, what are they? _____
What is/was your typical annual income, approximately? _____

Leisure Activities

How do you spend your leisure time? _____
What hobbies or interests do you have? _____
Have you had to stop doing or change how you're doing any of these activities since your illness/accident? _____

What else would be useful for us to know about you to help you?
_____
_____
_____

THANKS FOR COMPLETING THIS QUESTIONAIRE.