NEUROPSYCHOLOGICAL ASSOCIATES, LLC

Edward J. Barnoski, PhD., ABPP/ABCN
475 East Main Street, Suite 201
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 all the information requested. Be assured that all information given on this form and 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: ______________________

Cell: _________________ E-mail address: _______________________

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 REFERRED:

____

____

____

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 the 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?
____

Have you had or do you now have: (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, you are currently taking:

____

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?
Have you ever been treated for alcoholism?
12 Step groups like AA: Have you attended?
Other 12 Step groups? If so, which one (s):
____

Do you use any recreational or prescription medications 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 Heroin Quaaludes LSD Amphetamines

Smoking: Do you now smoke cigarettes? Yes_____ No______

How often/how many a day? _______________

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 before 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 (the 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? Yes_____ No_______

Do you think you will have any difficulties returning to work (if you 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 QUESTIONNAIRE.