THE UNIVERSITY OF NEW MEXICO
HEALTH SCIENCES CENTER
Center for Neuropsychological Services•915 Vassar Dr. NE Suite 170 Albuquerque, NM•Phone (505) 272-8833•Fax (505) 272-8316

Adult History Questionnaire

Please answer all questions AS FULLY AS POSSIBLE and bring with you on the day of your appointment.

Name of person completing form: _____ Relationship to patient: _____

Patient's full name: _____ DOB: _____ Age: _____

Sex: □ Male □ Female Are you: □ Right-handed □ Left-handed

What do you consider to be your ethnicity? _____

Where did you grow up? _____

Marital Status: □ Single

□ Married How long? _____

□ Life Partner How long? _____

□ Divorced How long married? _____ How long divorced? _____

□ Widowed How long married? _____ How long widowed? _____

Please list names & ages of all children:

_____

_____

Who lives in your home?

_____

What is (are) your source(s) of income? □ Employment □ SSI □ General Assistance

□ Retirement/Pension □ SSDI □ Food Stamps

□ Other: _____

If you have applied for disability: Was it granted? □ Yes □ No If yes, when granted? _____

What was the application based on? _____

Did you learn English as your first language? □ Yes

□ No At what age did you learn English? _____

What is your preferred/primary language now? _____

Name and phone number of emergency contact: _____ Relationship: _____

Current Concerns/Symptoms

For each item below, place a mark in the "Past" box if this was a problem for you in the past, and place a mark in the "Current" box if it is currently a problem for you (you can mark both "Past" and "Current" if necessary):

Attention	Past	Current	**Memory**	Past	Current
Easily distracted	□	□	Trouble remembering people's names	□	□
Have to reread material	□	□	Trouble recognizing familiar faces	□	□
Losing train of thought	□	□	Trouble remembering recent events (e.g., what you had for dinner last night)	□	□
Trouble following conversations	□	□	Trouble remembering recent conversations	□	□
Losing or misplacing personal items (e.g., glasses, keys, phone)	□	□	Trouble remembering things from longer ago (e.g., couple years ago)	□	□
Trouble multitasking	□	□	Trouble learning new things	□	□
Trouble planning complex activities (e.g., a party or vacation)	□	□	Having to write notes to remember things a lot more than usual	□	□
Trouble organizing your things	□	□	Repeating yourself	□	□
Trouble planning your day	□	□	**Language**		
Procrastinating	□	□	Trouble thinking of the right word ("tip-of-the-tongue")	□	□
Daydreaming or mind wandering	□	□	Using the wrong word	□	□
Trouble following multi-step instructions (e.g., a recipe)	□	□	Trouble understanding what others are saying in conversation	□	□
Trouble making decisions quickly	□	□	Slurred speech or problems w/articulation	□	□
Leaving projects unfinished	□	□	**Fine Motor**		
Trouble getting started on things	□	□	Trouble picking up or dropping things	□	□
Trouble getting back on track if interrupted	□	□	Trouble assembling pieces (e.g., furniture) or using tools	□	□
Spatial			Changes in your handwriting	□	□
Getting lost easily while driving, in stores or walking in your neighborhood	□	□	Tremors or shakiness in hands/arms or other body parts	□	□
Trouble reading maps	□	□	Numbness/tingling in hands or feet	□	□
Trouble judging distances	□	□	**Sensory**		
Unsure of your body position (e.g., bumping into things, misreaching for objects)	□	□	Change in vision	□	□
Everyday Activities			Change in hearing	□	□
Difficulty driving (e.g., running lights, accidents, hitting curbs)	□	□	Change in taste or smell	□	□
Trouble remembering to take medications	□	□	Change in touch sense	□	□
Trouble managing your finances (e.g., forgetting to pay bills)	□	□	**Walking/Balance**		
Trouble cooking (e.g., forgetting to turn off stove, leaving ingredients out)	□	□	Feeling uncoordinated	□	□
Trouble with housekeeping (e.g., dishes, cleaning, laundry)	□	□	Problems with balance	□	□
Trouble with bathing, grooming, dressing (e.g., need help shaving, reminders to brush teeth)	□	□	Falling down	□	□
			Feeling dizzy or lightheaded	□	□
			Trouble with or change in your walking	□	□

Are there any other changes or problems with your thinking? Please describe:

Are any of the difficulties described above interfering with your ability to carry out daily activities at home, work, school, or socially? Please explain:

Are there any current or ongoing stressors in your life (e.g., work, marital/partner stress, problems with coworkers, family member's poor health, problems with grown children)? Please explain:

Psychiatric/Emotional History

For each item below, place a mark in the "Past" box if this was a problem for you in the past, and place a mark in the "Current" box if it is currently a problem for you (you can mark both "Past" and "Current" if necessary):

	Past	Current		Past	Current
Hearing things or seeing things that other people don't	□	□	Social anxiety (e.g., talking in public, eating in front of other people)	□	□
Hoarding	□	□	Panic attacks	□	□
Unexplained inability to move parts of your body	□	□	Frequent or excessive worry	□	□
Racing thoughts	□	□	Obsessive thoughts or compulsive behaviors	□	□
Pressured Speech/More talkative than usual	□	□	Pulling out hair or eyelashes, or skin-picking	□	□
Decreased or absent need for sleep	□	□	Exposure to a life-threatening event (e.g., war, rape, physical assault)	□	□
Frequent or extreme mood swings	□	□	Frequent nightmares	□	□
Problems with temper or "rage attacks"	□	□	Flashbacks	□	□
Depression (e.g., sadness, increased crying, feeling "blue")	□	□	Feeling detached from your body ("out-of-body experience")	□	□
Extreme fears or phobias	□	□	Eating Disorder (e.g., anorexia, bulimia, binge-eating)	□	□

How would you describe your current mood (e.g., happy, sad, angry, nervous)? _____

Have you ever been hospitalized for emotional/psychiatric difficulties? □ No □ Yes

Have you ever received outpatient treatment for emotional or psychiatric problems (e.g., school counselor, psychotherapy, marriage counseling, etc.)? □ No □ Yes

IF YES ➔ Are you currently in counseling? □ No □ Yes

Do you have a history of physical, sexual or emotional abuse (including domestic violence)? □ No □ Yes

Has anyone ever pressured you or influenced you to give/transfer funds, real estate, or your personal property to them? □ No □ Yes

Have you ever taken medication for psychiatric problems? □ No □ Yes

IF YES ➔ Please list medication name, dose and note if past or current:

_____

_____

Have you ever thought about or attempted suicide? □ No □ Yes

IF YES ➔ Are you currently having any suicidal thoughts or behaviors? □ No □ Yes

Do you feel safe in your home? □ No □ Yes

Developmental History

Were you born: □ On time □ Early (how early? _____) □ Late (how late? _____)

What was your weight at birth? _____

Were there any complications during your mother's pregnancy or delivery with you?

IF YES ➔ □ Gestational diabetes
□ High blood pressure
□ High fever
□ Injuries/accidents
□ Other: (please describe) _____

While she was pregnant with you, did your mother use: □ alcohol □ cigarettes □ drugs □n/a

To the best of your knowledge, were you delayed in any of the following areas?

□ Walking □ Talking □ Toilet training

Please list any serious injuries, infections, or surgeries you had as a child (e.g., seizures, measles, mumps, rheumatic fever).

_____

_____

As a child or teenager, did you have any of the following? Please mark all that are applicable:

Academic learning problems	□	Poor listening skills	□
Memory problems	□	Poor concentration or short attention span	□
Problems with walking or handwriting	□	Poor organization	□
Bed wetting	□	Distractibility	□
Poor peer relations	□	Poor judgment	□
Repetitive behaviors/tics	□	Poor temper or impulse control	□
Anxiety/fears	□	Poor frustration tolerance	□
Depression	□	Excessive fighting	□
Suicidal ideation	□	Alcohol/drug abuse	□
Self-harm/cutting	□	Running away	□
Eating disorder	□	Difficulties with the law	□
Unusual beliefs/delusions	□	Fire setting	□
Hallucinations	□	Truancy	□
Hyperactivity	□	Cruelty to animals	□
Bullying others	□	Property destruction	□

Academic, Employment, & Social History

Please indicate the highest level of education you have completed:

□ 6th – 8th grade
□ 9th – 11th grade
□ 12th grade/high school diploma
□ GED
□ Some college: 1 year
□ Some college: 2-3 years
□ Associate's Degree (please specify major/concentration: _____)
□ Bachelor's Degree (please specify major: _____)
□ Master's Degree (please specify concentration: _____)
□ Doctoral Degree (e.g., MD, PhD, JD – please specify: _____)

Did you receive any special education services, resource room services, or tutoring services in school?
□ Yes □ No

Did you ever have to repeat a grade? □ No □ Yes (Please specify which grade(s): _____)
Did you ever skip a grade? □ No □ Yes (Please specify which grade(s): _____)

Did you have trouble learning to read? □ No □ Yes
Did you have trouble learning basic math? □ No □ Yes

Are you currently employed? □ No □ Yes

IF YES ➔ Where do you work? _____
What is your job title? _____
How long have you been at this job? _____
How many hours per week do you work? _____

IF NO ➔ Have you been employed in the past? _____
If so, where did you work and what was your title? _____
How long did you work at that job? _____
When was the last date you were employed? _____

Have you ever been arrested? □ No □ Yes
Do you currently have any legal problems (parole, probation, etc.)? □ No □ Yes
Do you have any lawsuits pending or do you intend to sue in the near future? □ No □ Yes

Medical History

Please check all the following that apply to you:

	Past	Current		Past	Current
Asthma	□	□	Metabolic Disorders	□	□
Brain Tumor	□	□	Multiple Sclerosis	□	□
Cancer	□	□	Obesity	□	□
Heart disease or heart attack	□	□	Stroke	□	□
Diabetes	□	□	TIA ("mini-stroke")	□	□
Headaches	□	□	Seizure	□	□
High Blood Pressure	□	□	Toxic Exposure	□	□
High Cholesterol	□	□	Thyroid Problem	□	□
Kidney Disease	□	□	HIV/AIDS	□	□
Lupus	□	□	Pulmonary (Lung) disease	□	□
Liver Disease	□	□	Other:	□	□
Meningitis/Encephalitis	□	□	Other:	□	□

Do you currently smoke cigarettes? □ No ➔ Have you ever smoked cigarettes in the past? □ No □ Yes

□ Yes➔ On average, how many cigarettes do you smoke per day? _____

How long have you smoked? _____

Have you ever used recreational drugs? □ No □ Yes

If yes ➔ Please check all the following that apply to you, either past or current (or both if applicable):

	Past	Current		Past	Current
Marijuana or Spice	□	□	Heroin	□	□
Cocaine (including crack cocaine)	□	□	PCP	□	□
Methamphetamine/Crystal Meth	□	□	Inhalant (e.g., "huffing")	□	□
Other hallucinogen (e.g., LSD, acid, psilocybin/mushrooms, peyote)	□	□	Prescription pain medications (not as prescribed)	□	□
Other (please describe):				□	□

Do you currently drink alcohol? □ No □ Yes

If yes, on average, how many drinks do you have per week?_____

Have you ever had periods of heavy alcohol use in the past? □ No □ Yes

Medical History (continued)

Have you ever had a head injury: □ No □ Yes

If yes ➔ Please list date(s):_____

After the head injury, did you experience any of the following?

□ Loss of consciousness (if yes, how long? _____)

□ Blurred vision/double vision

□ Dizziness

□ Nausea

□ Vomiting

□ Headaches

□ Changes in taste or smell

Did you seek medical treatment? □ No □ Yes

Were you admitted to a hospital? □ No □ Yes

If yes, how long? _____

Did you have a head CT or MRI scan?

What medications do you currently take? Please list dose if known.

_____

_____

Have you ever received psychological, neuropsychological, or cognitive testing? □ No □ Yes

If yes, please list: Date(s)_____

Doctor: _____

Facility or location: _____

Have you ever received: Physical therapy: □ No □ Yes

Occupational therapy: □ No □ Yes

Speech therapy □ No □ Yes

Have you ever had surgery (please list)? _____

_____

_____

Medical History (continued)

Do you have any trouble sleeping? □ No □ Yes

If yes ➔ Is it hard for you to fall asleep? □ No □ Yes

Is it hard for you to stay asleep? □ No □ Yes

What time do you usually go to bed? _____

What time do you usually wake up? _____

Do you take any medications or supplements to help you sleep? □ No □ Yes

If yes, please list: _____

Are you tired during the day or do you take naps? □ No □ Yes

Do you snore? □ No □ Yes

Do you have sleep apnea? □ No □ Yes

IF YES ➔ Do you use a CPAP or BiPAP machine? □ No □ Yes

Do you ever stop breathing or wake up gasping for air when asleep? □ No □ Yes

Do you have frequent vivid dreams or nightmares? □ No □ Yes

Are you a restless sleeper or do you have restless leg syndrome? □ No □ Yes

Do you experience chronic pain? □ No □ Yes

IF YES ➔ Where is the pain located in your body? _____

Are you in any pain right now? □ No □ Yes

IF YES ➔ Where is the pain located in your body? _____

Have you tried any pain treatments (e.g., massage, acupressure/acupuncture, medications)? □ No □ Yes

If yes, how helpful have the treatments been? _____

FAMILY HISTORY

Please indicate whether **any members of YOUR biological family (blood relatives only – do not include stepfamily or people related to you by marriage)** had any of the following (including children, brothers, sisters, parents, grandparents, aunts, uncles, cousins):

Alzheimer's disease or other dementia	□	Schizophrenia/Schizoaffective Disorder	□
Anxiety disorder (e.g., panic attacks, phobias)	□	Autism Spectrum Disorder	□
Bipolar Disorder (Manic Depression)	□	Attention-Deficit/Hyperactivity Disorder	□
Major Depression	□	Seizure Disorder (Epilepsy)	□
Learning Disabilities	□	Stroke or TIA ("mini-stroke")	□
Memory Problems	□	Alcohol or drug abuse/dependence	□
Intellectual Disability (mental retardation)	□	Suicide	□
Parkinson's disease	□	Other:	□
Huntington's disease	□	Other:	□
Psychiatric Hospitalization	□	Other:	□

Is there anything else that you would like to add?

_____

_____

_____

_____

_____

_____

_____

_____