Quest

Patient Label
Name: ____________________
DOB: ______________________
M#:_______________________

ADULT PATIENT REGISTRATION AND HISTORY QUESTIONNAIRE

(Adult History Questionnaire – Bozeman Health Neuropsychology)
I ACKNOWLEDGE THAT THIS FORM WILL BE INCLUDED IN THE PATIENT'S MEDICAL RECORD.
THANK YOU VERY MUCH FOR YOUR TIME AND ATTENTION IN FILLING OUT THIS FORM.

First Name ______________________ Last Name ______________________ DOB_____________________

Have you been treated before for your presenting symptoms? Y / N If yes, by ____________________________

Were you injured while working (Workers' Comp claim)? [ ]Yes [ ]No If yes, date of injury: ___/___/___

Suffer an accident? [ ]Yes [ ]No Mtr Vehicle Accident? [ ]Yes [ ]No Other Type? ________________

Highest Education: [ ] Less than high school (_ years; GED? Y/N) [ ] High School [ ] Bachelor's
[ ] Master's [ ] Doctoral degree Any technical training? Y / N If yes, type ________________ Years _____

Vocational Status: [ ] Full-time student [ ] Part-time student [ ] Homemaker [ ] Retired [ ] Unemployed
[ ] Disabled [ ] Full-time employed [ ] Part-time employed [ ] Other ____________________________________

Occupation _______________________ Employer ______________________ Work Phone _________________

Marital Status: [ ] Single [ ] Separated [ ] Divorced [ ] Married [ ] Partnered [ ] Widowed

Primary Language _____________ Other languages: Second ________________ Third ________________

How do you describe yourself from an ethnic or racial background? ____________________________________

Handedness [ ]Right [ ]Left [ ] Ambidextrous (for what? _________________________

Briefly Describe Your Problem ____

____

____

What is the most important question this evaluation can answer for you? _______________________________

____

SYMPTOMS

1.) Since your problems or symptoms began, which three have been the most troublesome or distressing for you?

1. ____

2. ____

3. ____

2.) Over the past three months, which problems or symptoms have improved or gotten worse?

Improved ______________________ / Worsened ______________________

______________________/______________________

______________________/______________________

______________________/______________________

3.) What do you think has caused your symptoms? ______________________

____

4.) Which problems or symptoms that you are having are most noticed by other people (i.e., which ones do they tell you about or complain about to you the most)?

1. ____

2. ____

3. ____

Please respond to the following items from your own perspective:

5.) Overall my symptoms have developed: ____________ Slowly ___________ Quickly

6.) My symptoms occur: _________________ Occasionally/Sometimes ________________ Often/Frequently

7.) Over the past 6 months my symptoms have: ______Stayed the same ______ Worsened

8.) In summary there is: ______ Definitely something wrong with me.
______ Possibly something wrong with me.
______ Nothing wrong.

EARLY HISTORY

(Complete all you can for this section; if you don't know something, write "DK" for "Don't Know" rather than leaving it blank)

9.) You were born: _____ On time _____ Prematurely _____ Late
10.) Your weight at birth: _____ lbs. _____ oz.
11.) Were there any problems associated with your birth (e.g., oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g., need of oxygen, special equipment used, convulsions, illness, etc.)? ______ Yes _______ No

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

	Accident
	Alcohol use
	Cigarette smoking
	Drug use (marijuana, speed, cocaine, LSD, etc.)
	Illness (toxemia, diabetes, high blood pressure, infection, RH incompatibility, etc.)
	Poor nutrition
	Psychological problems
	Other problems:

13.) List all medications (prescribed or over the counter) your mother took while pregnant [put DK, if no idea]

____

14.) During her pregnancy, did your mother live near a polluted area (e.g., toxic waste dump) or other hazardous area (nuclear plant, industrial area, pesticide sprayed area, etc.)?

____ Yes _____ No If yes, describe: ____

15.) Rate your developmental progress in very early years of your life, as it has been reported to you, by checking one description of each area:

	Early	Average	Late
Walking			
Language/Talking			
Toilet training			
Overall development			

16.) As a child, did you have any of these conditions: (check all that apply)

	Attentional problems		Head Injury
	Clumsiness		Hearing problems
	Developmental delay		Hyperactivity
	Learning disability		Frequent ear infection
	Speech problems		Vision problems
	Muscle tightness or weakness		Depression
	Loss of consciousness		
	Other psychiatric difficulty:		
	Other problems:		

MEDICAL HISTORY

CHILDHOOD MEDICAL HISTORY

17.) Check all the conditions that were diagnosed when you were a child.

	Allergies		Epilepsy or seizures		Pnuemonia
	Scarlet fever		Heart Problems		Fevers (104^0F or higher)
	Brain infection or disease		Immune system disease		Poisoning
	Rheumatic fever		Kidney problems		Polio
	Cerebral palsy		Lung (respiratory problems)		Cancer
	Chicken pox		Venereal disease		Asthma
	Colds (excessive)		Whooping Cough		Diabetes
	Oxygen deprivation		Tuberculosis		Measles
	Meningitis		Encephalitis		
	Other disease or disabilities:				

18.) As a child, were you exposed to excessive amounts of lead (e.g., eating paint chips, living next to high concentrations of automobile exhaust fumes, etc.)? _____ Yes _____ No
If yes, explain:____

19.) As a child, did you have an accident which required a hospital visit: _____ Yes _____ No
If yes, describe what happened:____

20.) Did you ever suffer a serious injury to your head? _____ Yes _____ No
If yes, explain the circumstances and any problems you had afterwards:
____
____
____

21.) List the medications that were regularly given to you as a child:

Medication	Reason for Medication
1.	
2.	
3.	
4.	
5.	

22.) Check all that apply:

	AIDS, ARC, or HIV+		Heart Disease
	Allergies		Huntington's Disease
	Arteriosclerosis (artery disease)		Hypertension
	Arthritis		Kidney Disease
	Blood Disease		Liver Disease
	Brain Disease		Loss of consciousness
	Cancer or chemotherapy		Lung (respiratory) Disease
	Parkinson's Disease		Malnutrition
	Psychiatric problems		Meningitis
	Senility (dementia)		Multiple Sclerosis
	Venereal Disease		Polio
	Hazardous substance exposure		Radiation exposure or therapy
	Thyroid Disease		Severe Snoring/Sleep Apnea
	Any other problems:		

23.) List any medications you currently take (over the counter or prescription medication), and the dosage.

Medication	Route (Oral, Injectable, etc)	Dosage	How often Taken
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
Others:			

24.) Do you have epilepsy or seizure disorder? _____ Yes _____ No
If yes, check the one you have been diagnosed with:

PARTIAL GENERALIZED _____UNCLASIFIED TYPE

	PARTIAL		GENERALIZED
	Simple partial (Jacksonian)		Absence (Petit small)
	Complex partial (psychomotor)		Myoclonic
	Partial evolving into generalized		Clonic
			Tonic
			Atonic
			Tonic-clonic (Grand mall)

	I have a Seizure Disorder but I don't know which type. Please describe it:

25.) Are you currently in psychotherapy or under psychiatric care? _____ Yes _____ No

26.) Have you ever been in psychotherapy or under psychiatric care? _____ Yes _____ No
If yes, please list date(s) of therapy and name(s) of professional(s) who treated you.

____
____
____

27.) Have you ever been prescribed medications for a mental or nervous condition (e.g., anti-anxiety medication, anti-depressants, major tranquilizer)? _____ Yes ______ No

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

____
____
____

SUBSTANCE USE HISTORY

ALCOHOL

29.) I started drinking regularly at age:
Less that 10 years old __, 10-15 __, 16-18 __, 19-21 __, over 21 __; No history of regular drinking ___

30.) I drink alcohol:

	Rarely or never		1-2 days/week
	3-5 days/week		Daily

31.) Preferred type(s) of drinks: ____

32.) Usual numbers of drinks I have at one time: ______________________________

33.) My last drink was:

	Less than 24 hours ago		24-48 hours ago		Over 48 hours ago

34.) 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, legal difficulty, problems at work, conflicts with family, accident, etc.) after drinking.
	I sometimes blackout after drinking.
	One or more people have told me that I should cut down on my drinking.
	I have been annoyed when someone has expressed concern about my drinking.
	I have felt guilty about my drinking in some way.
	I have needed an "eye-opener" (that is, a drink first thing in the morning).

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

		Presently Using	Used in the Past
	Amphetamines (including methamphetamines, “meth”)		
	Barbiturates (downers, etc.)		
	Cocaine or crack		
	Hallucinogenics (LSC, acid, STP, etc.)		
	Inhalants (glue, nitrous oxide, etc.)		
	Marijuana		
	Opiate Narcotics (heroin, morphine, etc.)		
	PCP (or “angel dust”)		
	Please list all other drugs:		

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

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

38.) Check all that apply:

	I have been in alcohol treatment
	I have gone through drug withdrawal
	I have used I.V. drugs
	I have been in drug treatment

39.) Do you smoke? _____ Yes _____ No
If yes, amount per day: ____

40.) 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:

MOTHER

41.) Is she alive? _____ Yes ____ No If deceased, what was the cause of her death?
____

42.) Mother’s occupation: ____

43.) Mother’s highest level of education: ____

44.) Does (or did) your mother have a known or suspected learning disability? _____ Yes ____ No

45.) Does (or did) your mother have a dementia such as Alzheimer’s, etc.? _____ Yes ____ No

FATHER

46.) Is he alive? _____ Yes ____ No If deceased, what was the cause of his death?
____

47.) Father's occupation: ____

48.) Father's highest level of education: ____

49.) Does (or did) your father have a known or suspected learning disability? _____ Yes ____ No

50.) Does (or did) your father have a dementia such as Alzheimer's, etc.? _____ Yes ____ No

SIBLINGS

51.) How many brothers and sisters do you have? ____
What are their ages? ____

52.) Are there any unusual problems (physical, academic, psychological) associated with any of your brothers or sisters? If yes, please describe: ____
____

CHILDREN

53.) How many children do you have?

	Boys	Age(s)	
	Girls	Age(s)	

54.) Any problems (physical, academic, psychological) associated with any of your children?
_______ Yes _______ No
If yes, describe: ____
____
____

55.) Please check all that existed in close biological family members (parents, brothers, sisters, grandparents, aunts, uncles), note who it was and describe the problem where indicated.

		Who?
	Epilepsy or seizures	
	Mental Retardation	
	Attention Deficit/Hyperactivity Disorder (ADD/ADHD)	
	Learning Disability or "dyslexia"	
	High Blood Pressure	
	Heart Disease	
	Stroke	

Neurologic (brain) Disease: Who?

	Alzheimer's Disease	
	Huntington's Disease	
	Multiple Sclerosis	
	Parkinson's Disease	
	Other Neurologic Disease	
	Describe:	

Psychiatric Illness: Who?

	Alcoholism	
	Bipolar Illness (manic depression)	
	Depression	
	Schizophrenia	
	Other Psychiatric Illness	
	Describe:	
	Speech or Language Disorder	
	Describe:	
	Other Major Disease or Disorder	
	Describe:	

PERSONAL HISTORY

MARITAL STATUS

56.) Current marital status: Married ___, Single ___, Divorced ___, Widowed ___, Separated ___, Partnered __

57.) Years married to current spouse: ____________________

58.) Number of times married? _________________________

59.) Current spouse's name: ____ Age: ___________________

60.) Spouse's occupation: ____

61.) Spouse's health: ______________ Excellent ______________ Good ________________ Poor

62.) Not married, but living with someone: ___________ Yes ___________ No
His/Her Age: ___________ His/Her Name: ____

EDUCATIONAL HISTORY

63.) Highest grade you finished or degree earned: ______________________________

64.) How would you describe your usual performances as a student:

	A & B
	B & C
	C & D
	D & F

Please provide any additional helpful comments about your academic performance:

65.) What was your best subject(s)? ______________________________
What was your weakest subject (s)? ______________________________

66.) Were you ever held back to repeat a grade? ______ Yes ______ No
If yes, what grade (s)? ____________________ Reason? ____________________

67.) Were you ever in any special class(es) or received special services? _____ Yes _____ No
If yes, what grade? ____________________Or age? ____________________
What type of class? ______________________________

OCCUPATIONAL HISTORY

68.) Current job title: ______________________________

69.) How long have you been on this job? ______________________________

70.) Current job responsibilities: ______________________________

71.) Prior jobs: Start with most recent:

a.
b.
c.
d.

72.) At any time on a job, were you exposed to toxic, hazardous, noxious, or otherwise dangerous or unusual substances (e.g., lead, mercury, radiation, solvents, pesticides, chemicals, etc.)?
________ Yes _______ No
If yes, explain: ______________________________
____

MILITARY HISTORY

73.) Branch: ______________________________

74.) Discharge rank: ____________________ Type of Discharge: ____________________

75.) Major military duties: ______________________________

76.) Did you sustain any physical injuries in the military? _______ Yes _______ No
If yes, describe: ______________________________
____

77.) Were you ever exposed to any dangerous or unusual substances during your service (e.g., Agent Orange, radiation, etc.)? ________ Yes _______ No

If yes, describe: ____

____

MEDICAL TESTING

78.) Check all the medical tests that recently have been done and report any abnormal findings:

		Check here if Normal	Abnormal Findings
	Angiography		
	Blood work		
	Brain Spect		
	CT Scan		
	EEG		
	Lumbar puncture or spinal tap		
	(MRI) Magnetic Resonance Imaging		
	Neurological Office Exam		
	Physician's Office Exam		
	Skull x-ray		
	Ultrasound		
	Other testing:		

79.) Identify the physician who is most familiar with your recent problems:

Name of Physician: ____

Address: ____

____

____

Phone:________________________ Fax: _______________________ Other:_____________________

Date of last medical check up: ____

Findings of last check up: ____

____

____

Date of last vision exam: ____

Date of last hearing exam: ____

80.) Have you had a prior psychological on neuropsychological evaluation? _____ Yes _____ No

If yes, complete this information:

Name of Psychologist:____

Address: ____

____

____

Phone:________________________ Fax: _______________________ Other:_____________________

Date of and reason for evaluation: ____

Findings of theevaluation:____

____

____

____

____

81.) Please use the space below to describe anything else you think it is important for us to know about your presenting problems, concerns, symptoms, etc.:

Print Name of Patient/Patient Representative: ______________________________ DOB: _____________

Signature of Patient/ Patient Representative: _______________________________ Date: _____________

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