KU WICHITA PSYCHIATRY & BEHAVIORAL SCIENCES
The University of Kansas

NEUROPSYCHOLOGY HISTORY QUESTIONNAIRE

Please complete this questionnaire **prior to your first neuropsychology appointment**. This information will help your clinician gain an understanding of the problems for which you were referred.			
Your Full Name	Date of Birth	Age	Sex
Who referred you to this clinic?		Today's Date	Race
What cognitive, emotional, or behavioral symptoms are you currently experiencing?			
How long have these been a problem?			
Have you ever had a neuropsychological or psychological evaluation? ☐ No ☐ Yes (Describe below)			
If yes, by whom?	Date of evaluation:		

Please send copies of any previous evaluations to your clinician prior to your first appointment.

EDUCATION & EMPLOYMENT	
Highest grade or degree completed:	Technical or trade school: ☐ No ☐ Yes
Field of study:	College or post-graduate school: ☐ No ☐ Yes
Are you currently working? ☐ No ☐ Yes	Year you retired or last worked:
Are you currently on disability? ☐ No ☐ Yes	Do you plan to apply for disability? ☐ No ☐ Yes
What is/was your occupation?	
How long did you hold your longest job?	
Did you serve in the military? ☐ No ☐ Yes	Branch:
Highest rank:	Type of discharge:

LEGAL INVOLVEMENT

Are you currently engaged in any lawsuits or other legal proceedings? ☐ No ☐ Yes
Are you considering any lawsuits or legal proceedings in the near future? ☐ No ☐ Yes
If yes, please describe:

MEDICAL HISTORY		
Please list any medications you are taking **currently**, for any reason:		
Name of Medication	Dose/Time of Day	Side Effects

Please check if you have ever experienced any of the following:					
☐	Memory problems	☐	Stroke	☐	Brain injury
☐	Concussion	☐	Seizures	☐	Staring spells
☐	Dizziness	☐	Frequent falls	☐	Clumsiness
☐	Numbness	☐	Headaches	☐	Blackouts/fainting
☐	High blood pressure	☐	High cholesterol	☐	Heart problems
☐	Speech problems	☐	Handwriting problems	☐	Episodes of confusion
☐	Hearing problems	☐	Vision problems	☐	Difficulty walking
☐	Sleep problems	☐	Sleep walking	☐	Major accident or injury
☐	Unusual childhood illnesses	☐	Hallucinations	☐	Depression
☐	Anxiety	☐	Obsessive/compulsive behavior	☐	Aggressive behavior
☐	Attention problems/ADHD	☐	Learning problems	☐	Skin problems
☐	Weight changes	☐	Digestive/GI problems	☐	Other
Please list any surgeries and the year they took place:					

MENTAL HEALTH HISTORY

How many alcoholic beverages do you drink in an average week?

What other substances do you use?

Have you ever attempted suicide? ☐ No ☐ Yes

Are you at high risk of attempting suicide in the near future? ☐ No ☐ Yes

Have you received mental health treatment? ☐ No ☐ Yes (See next page)

Date	Clinician / facility name	Type of treatment (medication, therapy, hospitalization)	Was it effective?

FAMILY HISTORY

Please note any family history (mother, father, sister, brother, daughter, son, spouse) of the following disorders:

Condition	Family Member	Condition	Family Member
Stroke		Depression	
Alzheimer's Disease		Anxiety	
Parkinson's Disease		Bipolar Disorder	
Dementia		Schizophrenia	
Seizures		Heart Disease	
Huntington's Disease		Learning Problems	
Cancer		Other:	

DEVELOPMENTAL HISTORY

Where were you born and raised?

As a child or adolescent, did you experience any of the following?

Physical abuse ☐ No ☐ Yes
Sexual abuse ☐ No ☐ Yes
Loss of a parent ☐ No ☐ Yes
Other trauma ☐ No ☐ Yes

Indicate any problems experienced during childhood or adolescence:

☐ Delayed speech
☐ Delayed motor development
☐ Excessive Shyness
☐ Excessive Aggression
☐ Hyperactivity
☐ Learning problems
☐ Illegal behavior
☐ Poor peer relationships
☐ Drug abuse
☐ Excessive alcohol use
☐ Depression
☐ School failure/dropout
☐ Runaway behavior
☐ Other: