Silicon Valley **Assessment**
NEUROPSYCHOLOGICAL ASSESSMENT, DIAGNOSIS, AND TREATMENT PLANNING

NEUROPSYCHOLOGY INTAKE QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and relevant to your current neuropsychological evaluation.

DEMOGRAPHIC HISTORY

Name: _____ Date of Appointment: _____

Gender: ☐ M ☐ F Age:_____ DOB: ____/_____/_____ Handedness: ☐ Right ☐ Left ☐ Ambidextrous

Address: _____

Phone: _____ Email: _____ Referring doctor: _____

Primary reason for today's evaluation:

_____

_____

ASSESSMENT HISTORY

Previous IQ, Educational, Psychological, or Neuropsychological Testing: ☐ Yes ☐ No	If Yes, Date(s): _____ ***If you have the report, please bring it w/ you to your appointment**

RECENT IMAGING/LABS

Head CT	☐ Yes ☐ No	Date(s): _____	Findings: _____
Brain MRI	☐ Yes ☐ No	Date(s): _____	Findings: _____
EEG	☐ Yes ☐ No	Date(s): _____	Findings: _____
PET Scan	☐ Yes ☐ No	Date(s): _____	Findings: _____
TSH/thyroid	☐ Yes ☐ No	Date(s): _____	Findings: _____
A1C:	☐ Yes ☐ No	Date(s): _____	Findings: _____
Vitamin B12	☐ Yes ☐ No	Date(s): _____	Findings: _____
Vitamin D	☐ Yes ☐ No	Date(s): _____	Findings: _____
Thiamine/B1	☐ Yes ☐ No	Date(s): _____	Findings: _____

MEDICAL HISTORY: PERSONAL AND FAMILY

Please check all that apply to yourself or to immediate family members (e.g., grandparents, parents, siblings, children)

	You	Family	Which family member(s)	Age/date of diagnosis
☐ Seizures/epilepsy	☐	☐		
☐ Multiple sclerosis	☐	☐		
☐ Stroke	☐	☐		
☐ Dementia (Alzheimer's, vascular, Lewy Body)	☐	☐		
☐ Concussion/traumatic brain injury	☐	☐		
☐ Brain tumor	☐	☐		
☐ Hydrocephalus	☐	☐		
☐ Migraines	☐	☐		
☐ Infection of the brain (meningitis, encephalitis)	☐	☐		
☐ Parkinson's disease	☐	☐		
☐ Fibromyalgia	☐	☐		
☐ Chronic pain	☐	☐		

	You	Family	Which family member(s)	Age/date of diagnosis
☐ Lupus	☐	☐		
☐ Chronic fatigue syndrome	☐	☐		
☐ Anemia	☐	☐		
☐ Thyroid disease	☐	☐		
☐ Diabetes type I/II	☐	☐		
☐ High blood pressure/hypertension	☐	☐		
☐ High cholesterol/hyperlipidemia	☐	☐		
☐ Cancer	☐	☐		
☐ Heart problems (heart attack, arrhythmia)	☐	☐		
☐ Exposure to toxic chemicals/waste/pesticides	☐	☐		
☐ Sleep apnea	☐	☐		
☐ Learning disability	☐	☐		
☐ ADD/ADHD	☐	☐		
☐ Medical complications during your mother's pregnancy or your birth	☐	☐		
☐ Late to start walking, talking or going to school	☐	☐		
☐ Other:	☐	☐		
☐ Other:	☐	☐		
☐ Other:	☐	☐		

If you checked yes to any of the above, please provide additional details below:

_____

_____

_____

PSYCHIATRIC HISTORY: PERSONAL AND FAMILY

Please check all that apply to yourself or to immediate family members (e.g., grandparents, parents, siblings, children)

	You	Family	Which Family Member(s)	Age/date of diagnosis
☐ Depression	☐	☐		
☐ Bipolar Disorder	☐	☐		
☐ Anxiety	☐	☐		
☐ Generalized	☐	☐		
☐ PTSD	☐	☐		
☐ Panic Attacks	☐	☐		
☐ Schizophrenia	☐	☐		
☐ Anger management problems	☐	☐		
☐ Suicidal thoughts	☐	☐		
☐ Suicide attempt(s)	☐	☐		
☐ Alcohol abuse	☐	☐		
☐ Other substance abuse	☐	☐		
☐ Other:	☐	☐		

If you checked yes to any of the above, please provide additional details below:

_____

_____

*For any of the psychological or psychiatric difficulties checked above, have **you** received any of the following treatments*?

☐ Individual Therapy ☐ Yes ☐ No	If Yes, When:_____ Current: ☐ Yes ☐ No
☐ Family Therapy ☐ Yes ☐ No	If Yes, When:_____ Current: ☐ Yes ☐ No
☐ Psychiatric Care/Medications ☐ Yes ☐ No	If Yes, When:_____ Current: ☐ Yes ☐ No
☐ Psychiatric Hospitalization ☐ Yes ☐ No	If Yes, When:_____ Reason? _____

PSYCHOLOGICAL, EMOTIONAL, INTERPERSONAL PROBLEMS

Please check all of the following that you have recently or currently experience

☐ Large or rapid fluctuations in mood	☐ Thoughts most people consider to be strange or bizarre
☐ Anxious, fearful, nervous	☐ Seeing, hearing, smelling, or feeling things that are not there
☐ Tense, high strung or have difficulty relaxing	☐ Delusions (believing things that are very unlikely to be true)
☐ Worry about many things	☐ Difficulty trusting others
☐ Fear that something terrible might happen	☐ Obsessive repetition of thoughts that bother you
☐ Irritability or reduced frustration tolerance	☐ Compulsive repetition of behaviors that are not really necessary
☐ Angry or have difficulty controlling temper	☐ Serious conflict between family members
☐ Depressed mood/sadness	☐ Marital problems
☐ Feeling like a burden on others	☐ Sexual difficulties
☐ Feeling embarrassed by your limitations	☐ Suffering the effects of prior physical, sexual, or emotional abuse
☐ Other:	

SOCIAL HISTORY

Place of birth: _____ If not US, date moved to US: _____

First Language: _____

If not English:

What language are you most comfortable with currently? _____ Age first learned English:_____

Age became fluent in English: _____ Years of formal English education: _____

Language spoken at home:_____ Language spoken w/ friends:_____

Mother's Level of Education: ☐ <9 ☐ 9-12 ☐ 12-16 ☐ >16 Occupation:_____

Father's Level of Education: ☐ <9 ☐ 9-12 ☐ 12-16 ☐ >16 Occupation:_____

Marital Status: ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed

Spouse's Age: _____ Education:_____ Occupation: _____

Children:

☐ M ☐ F Age: _____ Education:_____ Occupation: _____

☐ M ☐ F Age: _____ Education:_____ Occupation: _____

☐ M ☐ F Age: _____ Education:_____ Occupation: _____

☐ M ☐ F Age: _____ Education:_____ Occupation: _____

Who lives with you in your residence? _____

Do you need any assistance with:

☐ Transportation ☐ Taking medications ☐ Scheduling appointments ☐ Cooking

☐ Household chores ☐ Managing finances/bills ☐ Shopping

EDUCATION/OCCUPATION

Highest Grade completed:

☐ <12 ☐ GED ☐ High School ☐ Associates

☐ Bachelors ☐ MD/DO ☐MA/MS/MBA ☐ JD

☐ PhD ☐ Other

Typical High School Grades (circle): A's B's C's D's F's

High School GPA: _____

Any history of:

Special Education ☐ Yes ☐ No If yes, what grades? _____

Repeating a grade ☐ Yes ☐ No If yes, which grade?_____

IEP/504 Plan ☐ Yes ☐ No Diagnosis: _____

Tutoring ☐ Yes ☐ No If yes, what subject? _____

College Attended: _____

Major: _____ Grades: A's B's C's D's GPA: _____

Graduate School Attended: _____

Trade School/ Technical School Attended: ☐ Yes ☐ No

If Yes, Specialization: _____

Employed: ☐ Yes ☐ No ☐ Retired ☐ On Disability ☐ Looking ☐ Other: _____

If Yes, current occupation: _____ Employer: _____

If No, date of last employment:_____ Reason:_____

SLEEP

How would you rate your current sleep quality? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How many hours do you typically sleep per night? _____

How many hours did you sleep last night? _____

Are you currently taking medications to help you sleep? If Yes, what?

_____

Please check all that apply to your sleep: ☐ Snoring ☐ Gasping/choking ☐ Acting out your dreams ☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Early morning awakening

Do you use a CPAP, bipap, or dental device for sleep apnea? ☐ Yes ☐ No

SUBSTANCE USE

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No

If Yes, which substance(s): _____ Treatment location:_____ Treatment date:_____

Alcohol

On average, how many drinks do you consume in a week?_____

What is the most number of drinks you drink a day? _____

Which alcoholic beverages do you drink? (e.g. beer, wine, liquor): _____

Illicit Substances/Prescription Medications

Have you ever used illicit substances? ☐ Yes ☐ No

If Yes, list which ones:_____

If Yes, have you used any in the past 3 months? ☐ Yes ☐ No

Tobacco

Have you ever smoked nicotine cigarettes? ☐ Yes ☐ No

If current: How many packs/day? ___ How many years? _____

If quit: How many packs/day? _____ When did you quit?____

Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning? ☐ Yes ☐ No

MEDICATION HISTORY

Have you ever taken medications for:	Current	Past	Which Medications?	Dates:
Depression (e.g., Prozac, Zoloft)	☐	☐		
Anxiety (e.g., Ativan, Xanax)	☐	☐		
Sleep (e.g., Ambien, Lunesta)	☐	☐		
Chronic pain/headaches (e.g., Vicodin, Neurontin, Pamelor)	☐	☐		
ADD/ADHD (e.g., Adderall, Ritalin)	☐	☐		
Dementia (e.g., Aricept)	☐	☐		
Seizures (e.g., Topamax, Keppra)	☐	☐		
Other:	☐	☐		

CURRENT MEDICATIONS

Medication: **Reason:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____