Psychological & Neuropsychological Testing Patient Questionnaire

I. IDENTIFYING INFORMATION

Name: Date:

Gender Identity:

☐ Female ☐ Male ☐ Transgender ☐ Non-Binary ☐ Other:

Preferred Pronoun:

☐ She/Her ☐ He/Him ☐ They/Them ☐ Other:

DOB: Age:

Race/ Ethnicity:

First Language: Second Language: Relationship Status:

-select-

Current Living situation:

-select-

MINORS ONLY:

Parent/Guardian Name(s):

Current Grade: School: SPED/ IEP:

☐ Yes ☐ No

II. Reason for Referral

Referred by: Name:

-select-

What is the target issue or concern to be addressed through testing?

Who are your current treatment providers?

☐ Primary Care Physician: date of last appt:

☐ Therapist: date of last appt:

☐ Psychopharm: date of last appt:

☐ Other Specialist: date of last appt:

Psychological & Neuropsychological Testing Patient Questionnaire

III. PLEASE IDENTIFY CURRENT SYMPTOMS & DURATION OF SYMPTOMS

SYMPTOMS	NEVER	PAST	CURRENT Past 3-6 months	COMMENT
Sad or Depressed mood	☐	☐	☐	
Irritability / Anger	☐	☐	☐	
Loss of Interest / Low Motivation	☐	☐	☐	
Feelings of Guilt or Shame	☐	☐	☐	
Grief or Bereavement due to loss	☐	☐	☐	
Eating significantly more or less	☐	☐	☐	
Sleeping Problems	☐	☐	☐	
Hopelessness	☐	☐	☐	
Suicidal Thoughts	☐	☐	☐	
Self-Harming Behaviors (ex. cutting, burning)	☐	☐	☐	
Anxiety (General, Social, Performance, Separation)	☐	☐	☐	
Panic Attacks	☐	☐	☐	
Episodes of Mania/ Hypomania that include: Elevated Mood lasting days with any of the following: Inflated self-esteem/ grandiose thinking, Agitation, Fast or pressured speech, Decreased need for sleep	☐	☐	☐	
Restrictive Eating: starvation, binging & purging, food avoidance	☐	☐	☐	
Major weight gain or loss	☐	☐	☐	
Inattention: trouble with concentration or focus, easily distracted	☐	☐	☐	
Hyperactivity: overtalkative, tendency to interrupt, impatient, fidgety, restlessness	☐	☐	☐	
Poor Memory / Forgetfulness in daily activities	☐	☐	☐	
Intrusive, Unwanted or Obsessive thoughts	☐	☐	☐	
Rigid or Compulsive Behavior	☐	☐	☐	
Social Problems/ Difficulty establishing or maintaining relationships	☐	☐	☐	
Episodes of dissociation/ preoccupied & withdrawn behavior	☐	☐	☐	
Sensory Sensitivities (hearing, vision, touch, taste & smell)	☐	☐	☐	
Restricted and repetitive behavior, insistence on sameness	☐	☐	☐	
Delusions/Hallucinations (hearing, seeing, smelling or feeling things that others don't)	☐	☐	☐	
Substance dependence/abuse or Relapse	☐	☐	☐	
Arrested, Incarcerated or Probation	☐	☐	☐	
Nightmares/ Night Terrors	☐	☐	☐	
Other:	☐	☐	☐	

What interventions have been implemented and what was the outcome?

IV. CURRENT MEDICATIONS (medical and psychotropic)

V. MEDICAL / HEALTH HISTORY

History of chronic health condition (e.g. diabetes), Past Medical condition, Current medical conditions:

Chronic Pain condition?

Genetic condition/ Chromosomal disorder?

Past Surgeries or other medical procedures?

History of head injury, concussion, or loss of consciousness

VI. MENTAL HEALTH/ TREATMENT HISTORY

Past Diagnosis and approximate date/year diagnosed?

Prior evaluation/ neuropsychological testing? ☐ Yes ☐ No
If yes, when was your most recent evaluation and what were the circumstances? What were the conclusions or results of prior testing?

Risk Behavior

Do you have a history of Suicide Attempts (i.e., a specific plan for harm)? ☐ Yes ☐ No
Do you have a history of Self-Harm or Self-injurious behavior? ☐ Yes ☐ No
Please explain circumstances and/or provide dates for any serious injuries that required medical Attention:

Acute Care Treatment

Do you have a history of being admitted to an Inpatient psychiatric hospital unit? ☐ Yes ☐ No
Do you have a history of participating in a Partial Hospitalization program? ☐ Yes ☐ No
Do you have a history of participating in Detox/ Rehab? ☐ Yes ☐ No
If yes to any of the above acute treatment, please provide an explanation:

Psychological & Neuropsychological Testing Patient Questionnaire

VII. DEVELOPMENTAL HISTORY

Was your mother in good health or were there any pre-natal concerns? If yes, please explain:

Were there any complications in Birth/Labor/Delivery? If yes, please explain:

Milestones:

Motor Skills: -select-

Speech & Language: -select-

Personal & Social: -select-

Please provide an explanation for any developmental concerns or delays noted above:

Concerns, Notable Behaviors or Experiences:

During your Early Childhood?

During Middle Childhood /Pre-Adolescence (age 10-13):

During Adolescence (age 14- 18):

Adverse Childhood Experiences & Exposure Toxic Stress (age 0-18)

- ☐ Abuse ☐ Neglect ☐ Chronic poverty ☐ Homelessness ☐ Witnessed household violence
- ☐ Exposure to household member with serious and persistent mental illness
- ☐ Exposure to household member with substance use or abuse problem
- ☐ Parental separation or divorce ☐ Death or loss of a caregiver
- ☐ Household member arrested or incarcerated ☐ Involvement with child protective services
- ☐ Involvement with juvenile justice system

Traumatic/ Distressing experiences during Adulthood (age 19+)?

Family Mental Health History

Mother	
Father	
Siblings	
Maternal Grandparents	
Paternal Grandparents	

Psychological & Neuropsychological Testing Patient Questionnaire

VIII. EDUCATION/ ACADEMIC HISTORY

Highest level of education completed?

-select-

Currently Enrolled in School or Planning to Return? ☐ Yes ☐ No

-select-

History of special education, IEP/504 plan? Other Learning issues? Behavioral issues? Alternative learning placement?

IX. EMPLOYMENT HISTORY

Current employment?

Problem or Impairment in work environment?

Past work environments?

X. SUBSTANCE ABUSE/ USE HISTORY

☐ Caffeine use Amount of use: cups/day

☐ Nicotine/tobacco/vape Frequency/ Amount

☐ Marijuana use Frequency of use:

☐ Alcohol Use Frequency/ Amount

Consequences of Use of Legal Substances (e.g., DUI/DWI, marijuana charges)?

Illicit Substance	Age at First use	Date of last use & Amount	Consequences of use
-select-			
-select-			
-select-			
-select-			