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NEUROPSYCHOLOGICAL QUESTIONNAIRE

Self-Report Version

Please answer these questions to the best of your ability and bring this form to your appointment with Dr. DeBellis on _____ at _____.

IDENTIFYING INFORMATION:

Name: _____
Date of Birth: _____
Age: _____
ID/Claim #: _____
Phone #: _____
Address: _____

REFERRAL INFORMATION:

Who referred you for this evaluation? _____
What information would you like to gain through this evaluation? _____
_____

HISTORY OF CURRENT PROBLEM/INJURY/ILLNESS:

1. **Date** injury or illness started: ___/___/___
2. Illness/injury can be labeled as:
   ____ Head injury
   ____ Stroke
   ____ Other (please specify) _____

3. Please describe in detail the **accident or illness**: _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

4. Were you taken to an **emergency room**? __Yes, __ No. If yes, where? _____
   _____
5. Were you **hospitalized**? __Yes, __No. If yes, where? _____
   _____
6. What **diagnostic** procedures (e.g., **CT** scan, **MRI** scan, **EEG**) have been done and what were the results? _____
   _____
7. Did you have **surgery**? __ Yes, __ No. If yes, for what? _____
   _____
   _____
8. Were there any **complications** such as increased intracranial (in the head) pressure/ swelling, meningitis or infection? __ Yes, __ No. If so, please describe: _____
   _____
9. Did you receive **inpatient** rehabilitation services? __Yes, __No. If yes, please describe:
   _____
   _____
10. Did you receive **outpatient** rehabilitation services? __Yes, __No. If yes, please describe:
    _____
    _____

describe: _____
_____
_____
_____
_____

12. Please list any medications you **currently** take:

	Medication		**Dosage**
1.	_____	1.	_____
2.	_____	2.	_____
3.	_____	3.	_____
4.	_____	4.	_____
5.	_____	5.	_____

13. Please describe **current alcohol** use in terms of what you drink, how much, and how often: _____
14. Please describe **current street drug** use in terms of what you use, how much and how often: _____
15. Please describe any **current** exposure to **toxic substances** (e.g., solvents, pesticides, lead) in your workplace or living environment: _____

PRIOR MEDICAL HISTORY:

1. Were you born: ____ on time, ____ prematurely, or ____ late?
2. What was your **birth weight**? ____ lbs., ____ oz.
3. Please describe any problems you are aware of that were associated with your birth or the immediate time period after birth: ____ oxygen deprivation, ____ unusual birth position, _____other (please describe): _____
4. Please check all that applied to your mother while she was **pregnant** with you:
   - ____ Alcohol use
   - ____ Recreational or street drug use
   - ____ Exposure to environmental toxins
   - ____ Cigarette smoking
   - ____ Malnutrition
   - ____ Accidents
5. List all medications (prescribed or over-the-counter) your mother took while pregnant: __
   _____
6. Did your **developmental progress**, such as walking and talking, occur ____ early, ____ average, or ____ late?
7. As a child, did you have any developmental problems? If so, please describe: _____
   _____
8. As a child, were you around any toxic waste, toxic fumes of any kind, or lead?

___ Yes / ___ No. If yes, please explain: _____

9. How was your **nutrition** in childhood? _____
10. Please describe any psychiatric, neurological (including dementia), substance abuse, or academic problems that **close relatives** have had: _____

_____

11. By whom were you raised? _____
12. Please describe any **previous** concussion/loss of consciousness or other brain injury: ___

_____

13. Please describe any **previous** hospitalization, neurological illness, serious injury, or surgery: _____
14. Please list any other illnesses or health problems you have ever had: _____

_____

15. Please describe any **history** of heavy or frequent **alcohol** use: _____

_____

16. Please describe any **history** of heavy or frequent **drug** use: _____

_____

17. Please describe any history of **legal or job problems** due to alcohol or drug use: _____

_____

!8. Please describe any history of exposure to **environmental toxins** at work or elsewhere: __

_____

19. Please describe any **mental health problems or diagnoses** you have ever had: _____

_____

20. Please describe any **mental health treatment** you have ever received: _____

_____

EDUCATIONAL AND CULTURAL BACKGROUND:

1. What is your **primary language**?: _____
2. What is your **cultural or ethnic background**?: _____
3. What is the **highest** grade that you completed in school? _____
4. Were you labeled as "**learning disabled**" or placed in any **special education** classes? ___ Yes, ___ No. If yes, please describe: _____

_____

_____

5. Did you have any **behavioral or disciplinary problems** in school? __ Yes, __No. If yes, please describe: _____

_____

_____

_____

What were your **best subjects**? _____

8. What were your **worst subjects**? _____
9. As a student, were you _____ average, _____ above average, or _____ below average?
10. Please describe any **grade point averages** or **standardized test scores** (e.g., SAT, IQ, achievement tests, etc.) that you earned: _____

_____

_____
_____
_____

11. Please describe any **special accomplishments or strengths** as a student: _____
_____

WORK HISTORY:

1. Were you ever in the **military**? __ Yes, __No. If yes, what rank and branch? _____
_____ For how long? _____ Type of discharge: _____
Military jobs included: _____

2. **Prior jobs** (please **start with the most recent**): **Months/Years**

a. _____
b. _____
c. _____
d. _____
e. _____
f. _____
g. _____
_____

3. What work were you doing **at the time of your injury/illness**? _____
_____
For how long? _____ Salary?_____
4. Did you continue to work at this job after your injury/illness? ____ Yes, ____ No
5. What is your **current job**, if any? _____

CURRENT LIVING SITUATION:

1. Currently, are you married, divorced, separated, single? _____
2. Who lives with you? _____
3. Where do you live?_____
4. Is anyone your **conservator or legal guardian**?_____
5. Please describe your **typical daily activities**: _____
_____
_____
_____
6. What **help or supervision** do you need from others? _____
_____
_____
7. Do you currently drive? _____
8. Do you have a **valid** California driver's license? _____
9. Do you currently have **seizures**? _____

10. Do you rely on your own car, a borrowed car, rides from friends or family, or public transportation? _____

11. What is your current source of income or financial support? _____

_____

Have you been involved in **lawsuits** for this or any other injury? ____ Yes, ____ No

If yes, please describe the outcome or current status: _____

Please read this statement and sign below (you may wait until you have had a chance to ask questions)**:** I understand the general nature and purpose of this evaluation and agree to be evaluated. I authorize the release by Dr. Wanlass or his staff of psychological and other personal background or health information to my doctors; to my attorney; to the responsible medical, workers' compensation, liability, or disability insurance company and the legal and health care professionals they employ to work on my case; and to the other persons listed below. I also authorize these parties to release the same types of information to Dr. Wanlass. I understand that this release or exchange of information may be done for the purposes of increasing my health care providers' understanding of my condition, coordinating treatment, managing legal or insurance aspects of my case, responding to subpoenas, or obtaining payment for services. I understand that this authorization will be valid for a period of three years, except that I may revoke it at any time by written request, and that I may ask for and receive a copy of this form.

Signature: _____ **Date:** _ _____

PROBLEMS:

Please describe the problems you are having **now** and indicate whether you **also** had these problems **before** your injury or illness.

	Now	**Before**
1. Difficulty with **problem solving or reasoning**? If so, please describe: _____ _____	_____	_____
2. Problems with **speed of thinking**? If so, please describe: _____ _____	_____	_____
3. Problems with **concentration**? If so, please describe: _____	_____	_____

_____

4. Problems with **memory**? _____ _____
If so, please describe: _____
_____

5. Problems with **speaking, listening, writing, or reading**? _____ _____
If so, please describe: _____
_____

6. Problems with **strength or coordination**? _____ _____
If so, please describe: _____
_____

7. Problems with **vision**? _____ _____
If so, please describe: _____
_____

8. Problems with **spatial** ability or sense of direction? _____ _____
If so, please describe: _____
_____

9. Problems with sense of **hearing, touch, or smell**? _____ _____
If so, please describe: _____
_____

10. Problems with **psychological or social adjustment**
or aspects of your life that are **stressful**? _____ _____
If so, please describe: _____
_____

Mood Questionnaire (H.A.D.S.)

This questionnaire is designed to help your doctor know how you feel. Read each item and **underline** the reply which comes closest to how you have been feeling in the **past week**. Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than a long thought-out response.

I feel tense or 'wound up':	**I still enjoy the things I used to enjoy:**
Most of the time…	Definitely as much
A lot of the time..	Not quite so much.
From time to time, occasionally.	Only a little..
Not at all	Hardly at all…
I get a sort of frightened feeling as if something awful is about to happen:	**I can laugh and see the funny side of things:**
Very definitely and quite badly…	As much as I always could
Yes, but not too badly..	Not quite so much now.

A little, but it doesn't worry me.	Definitely not so much now..
Not at all	Not at all…
Worrying thoughts go through my mind:	**I feel cheerful:**
A great deal of the time…	Not at all…
A lot of the time..	Not often..
From time to time but not too often.	Sometimes.
Only occasionally	Most of the time
I can sit at ease and feel relaxed:	**I feel as if I am slowed down:**
Definitely	Nearly all the time…
Usually.	Very often..
Not often..	Sometimes.
Not at all…	Not at all
I get a sort of frightened feeling like 'butterflies' in the stomach:	**I have lost interest in my appearance:**
Not at all	Definitely…
Occasionally.	I don't take so much care as I should..
Quite often..	I may not take quite as much care.
Very often…	I take just as much care as ever
I feel restless as if I have to be on the move:	**I look forward with enjoyment to things:**
Very much indeed…	As much as ever I did
Quite a lot..	Rather less than I used to.
Not very much.	Definitely less than I used to..
Not at all	Hardly at all…
I get sudden feelings of panic:	**I can enjoy a good book or radio or TV program:**
Very often indeed…	Often
Quite often..	Sometimes.
Not very often.	Not often..
Not at all	Very seldom…

how well do these statements describe how you have been over the past 2 weeks?

	False	**Partly True**	**Very True**
1. I often feel sad or empty.			
2. I have lost interest in most things.			
3. I don't enjoy the things that I am able to do.			
4. I don't laugh or smile much any more.			
5. Things bother or annoy me more easily now.			
6. I often feel like crying.			

7. I don't care much about other people any more.			
8. I often feel like a failure.			
9. I feel very bad about things I have done.			
10. I don't feel much romantic or physical attraction towards anyone.			
11. I don't have much that I want to do.			
12. I don't have much to look forward to.			
13. I often think about dying.			
14. My life does not seem worth much.			
15. I don't care much whether I live or die.			
16. I feel like the most unhappy person on earth.			
17. I never feel down or discouraged.			
18. I am depressed, and my mood stays the same all day long every day.			
19. My thoughts are always cheerful.			
20. I often feel restless.			
21. I often feel tired or slowed down.			
22. I sleep too much.			
23. It is hard for me to stay asleep.			
24. It is hard to think, concentrate, or make decisions.			
25. I eat too little or too much.			

Now please go back through these same items one more time and respond the way you were right before yo illness). Mark using the letter "B" to indicate how you were right before your injury (or illness). how well do these statements describe how you have been over the past 2 weeks?

	False	Partly True	Very True
1. I seem to worry more than others.			
2. I lack confidence.			
3. I have so many worries that it is hard to relax.			
4. I rarely feel safe and secure.			
5. I feel a sense of fear or dread.			
6. I often have feelings of intense fear or panic when there is no real danger.			

7. I often have fears about going crazy.			
8. I have much stronger fears than most people about certain things, places, or activities.			
9. Because of fear, I avoid activities, things, or places that most people would not avoid.			
10. Bad memories or nightmares often bother me.			
11. I am more jumpy or easily startled than others.			
12. I often try to avoid certain social situations because they make me nervous.			
13. I often worry about what others think of me.			
14. Often I can't stop doing things over and over (like counting, re-checking, washing, or cleaning).			
15. Often I can't stop certain distressing thoughts from running through my mind.			
16. I have been too stressed to be able to sleep at all.			
17. I am always confident.			
18. I constantly feel startled.			
19. I have no fears or worries.			
20. I have fears that I am about to die or lose control.			
21. I worry so much that it is hard to fall asleep.			
22. My muscles are tense or tight from stress or worry.			
23. I often sweat from stress even when it's not hot.			
24. I am often so nervous that my breath or heart rate seems to speed up or become uneven.			
25. I am often so worried or tense that my appetite or ability to digest food is affected.			

Now please go back through these same items one more time and respond the way you were <u>right before your injury (or illness)</u>. Mark using the letter "<u>B</u>" to indicate how you were right <u>before</u> your injury (or illness).

This form should be filled out by someone (e.g., co-worker, supervisor, friend, relative) who has known you well before and after your injury.

Please describe the problems _____ is having **now** and indicate whether he/she **also** had these problems **before** the _____ injury. Please put **your** name, relationship to the person you are describing, and today's date here:

_____

	Now	**Before**
1. Difficulty with **problem solving or reasoning**? If so, please describe: _____	_____	_____
2. Problems with **speed of thinking**? If so, please describe: _____	_____	_____
3. Problems with **concentration**? If so, please describe: _____	_____	_____
4. Problems with **memory**? If so, please describe: _____	_____	_____
5. Problems with **speaking, listening, writing, or reading**? If so, please describe: _____	_____	_____
6. Problems with **strength or coordination**? If so, please describe: _____	_____	_____
7. Problems with **vision**? If so, please describe: _____	_____	_____
8. Problems with **spatial** ability or sense of direction? If so, please describe: _____	_____	_____

9. Problems with sense of **hearing, touch, or smell**? _____ _____
If so, please describe: _____
_____

10. Problems with **psychological or social adjustment**
or aspects of his/her life that are **stressful**? _____ _____
If so, please describe: _____
_____