Neuropsychological Services of Oregon, LLC

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In preparation for your evaluation, please complete the questions on this form. Please answer as completely and with as much detail as possible. Feel free to write on the back or to use additional sheets when necessary. Although we prefer that you complete the form yourself, you may ask a spouse, relative, or significant other for help if needed. Please answer all the questions which pertain to you. We prefer that you mail or fax this questionnaire so that it can be reviewed before your appointment. If there is not time to mail or fax it, you may bring it with you. If you have any questions, please call us at 541-306-6456.

First Name: _____ Middle: _____ Last Name: _____

Home Address: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Referred by: _____

If another person assisted in filling out this form, please enter the information below:

Name: _____

Relationship to Patient: _____

GENERAL INFORMATION

Primary Care Doctor: (include name and address) _____

_____

Age: _____ Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

Circle One: Left-handed Right-handed Mixed

Circle One: Single Married Separated Divorced Widowed

Military Service: Years _____ to _____ Type of Discharge: _____

MEDICAL HISTORY

1. Briefly describe what problem(s) (symptoms) caused you to seek help from your current doctor (that lead to the referral to see us).

2. Approximate date when these problem(s) began: _____. Have your symptoms worsened, gotten better, or stayed the same since they first began? Explain, if necessary.

3. To the best of your knowledge, what is the cause of these problems?

4. What is your understanding of why you doctor referred you for this evaluation?

5. Please list your current medications (with dosages), reasons you take them, how long you have been on them, and any side effects you have noticed (e.g., nausea, sleepiness, etc.):

Medication	Dosage	Reason	How Long?	Side Effects (if any)

6. List below the names of doctors who currently are treating you.

Name	Address	Type of Doctor (e.g., Family Doctor, Neurologist, Internist, Psychiatrist, Psychologist, etc.)

7. List below all prior hospitalizations, along with dates, reason for hospitalizations, and types of treatment you received.

Approximate Date	Hospital	Reason	Treatment

8. Have you had any of the following tests performed? Please indicate date(s). If you have copies of medical records pertaining to these tests, please bring them to the evaluation with you.

	Date
CT/MRI/FMRI Scan	
EEG	
Spinal Tap	

9. Please rate your overall health at this time.

Circle One: Poor Fair Good Excellent

10. Please indicate whether you or a member of your family has ever had any of the following illnesses:

	Self	Family Member
Cancer/Tumor		
Diabetes		
High Blood Pressure		
Heart Disease		
Heart Attack/Angina		
Lung Disease		
Multiple Sclerosis		
Stroke		
Head Injury*		
Other Loss of Consciousness		
Seizures/Epilepsy		
Learning Disability		
Parkinson's Disease		
Huntington's Disease		
"Senility"/Alzheimer's Disease		

Psychiatric Illness _____ _____

Depression _____ _____

Other _____ _____

*For any head injury you have had, please indicate below when it occurred (date), how it occurred (e.g., in a car accident, as a result of physical abuse, etc.), whether you lost consciousness and for how long, and any treatment you received.

11. At any time, have you had a psychiatric, psychological, or neurological evaluation and/or treatment?

Date	Name of Doctor	Location	Nature of Problem

12. Have you ever been to our office before or have you had a neuropsychological evaluation performed before? If so, when? By whom? _____

13. Do you smoke tobacco? If so, how much? _____

14. Do you smoke marijuana? If so, how much? _____

15. Do you drink alcohol? If so, how many drinks per week? _____

    a. Did you ever have a period of time when you drank alcohol to excess or had problems using non-prescription drugs? If so, when?

    b. Have you ever received treatment for alcohol or chemical dependency? If so, when?

EDUCATIONAL AND OCCUPATIONAL HISTORY/CURRENT INTERESTS

1. How many years of education did you complete? _____

2. Some people enjoyed school, while others attended because it is required. In your own words, describe your attitude toward school.

3. Did you ever repeat any grades or need extra help in any school subjects? Receive special education services?

4. List activities (organizations, sports) in which you currently participate. Also, list hobbies/interests you currently pursue.

5. Has your current illness or problems affected your ability to do your job? Your social life? If retired/unemployed, has it affected your ability to perform daily activities and chores? If so, please describe.

6. Does your present work or daily activities satisfy you? (If not, in what ways are you dissatisfied?)

7. In the table below, please outline your work history, starting with your present job and working backwards. If you are retired or unemployed, indicate this in the first row and complete the rest of the table with your past employment(s).

Occupation	Approx. Dates	Title/Duties

COMPENSATION/LITIGATION

1. Are you currently receiving disability compensation as a result of current or past illness?

   Yes _____ No _____ If Yes, please specify:

2. Are you currently involved in or planning a lawsuit or other legal action related to the illness for which you are being evaluated? If yes, please specify.

INSURANCE/PAYMENT INFORMATION

Are you covered by an insurance health plan?

Primary Insurance: _____ Secondary Insurance: _____

Responsible party, if other than patient: (who is responsible for payment of all costs incurred?)

First Name: _____ Middle: _____ Last: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ SSN: _____

Employer: _____ Work phone: _____

Responsible party's relationship to patient: Spouse [ ] Child [ ] Parent [ ] Other: _____