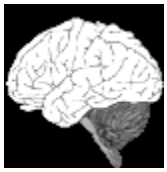
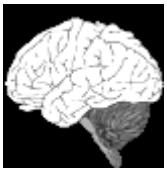


Joseph F. Kulas, Ph.D., ABPP
Board Certified
Clinical Neuropsychologist



The Exchange
Suite 344
270 Farmington Avenue
Farmington, Connecticut 06032

Phone: (203) 805-8527
Fax: (888) 494-0373
JosephKulas.PhD@neuropsychologyct.org

BACKGROUND QUESTIONNAIRE

Confidential Information

In preparation for your Neuropsychological Evaluation, I ask that you complete the following questions. Please answer them as completely and in as much detail as possible. Feel free to write on the last page of the questionnaire or use additional sheets, as necessary. I prefer that you complete the questions yourself, but, if necessary, you may have a relative or friend assist you. Please bring this completed questionnaire with you to your evaluation. If you have any questions, please contact Dr. Joseph Kulas at (203) 805 - 8527.

Patient Name _____ **Date Completed** ____/____/____

Phone H)_____

Address _____ **W)**_____

Street **Cell)**_____

_____

City **State** **Zip** **DOB** ____/____/____ **Age** ____

Handedness R L B **Marital** _____ **Education**_____

(Highest Grade Completed)

If another person assisted in completing this form, provide information about him/her:

Name _____ **Relationship to Patient** _____

Phone H) _____

Address _____ **W)**_____

Street **Cell)**_____

_____

City **State** **Zip**

If necessary, may this person be contacted for additional collateral information?_____

Referral Information: Who referred you for this evaluation?_____

To the best of your knowledge, why were you referred for this assessment?:

_____
_____
_____
_____

What would you like to learn about yourself or accomplish from this evaluation?

_____
_____
_____

Medical Information:
Briefly describe what problems or symptoms led you to seek help from your current treatment providers.

_____
_____
_____
_____
_____
_____

List the five problems or symptoms that currently cause you the most difficulty (1. is worst).

1. _____
2. _____
3. _____
4. _____
5. _____

Approximately when did these symptoms begin?_____

Have your symptoms (circle 1): Gotten worse? Gotten Better? Stayed the Same?

To the best of your knowledge, what is/was the cause/causes of these problems?

_____
_____
_____
_____

Current Physicians/Therapists: Please list all current treatment providers.

Name	City, State	Phone	Specialty	How Long?

Current Medications: Please list all medications you are taking (including over-the-counter drugs).

Medication	Reason Taking	How Long?

Prior Psychological/Neuropsychological Evaluations or Neurological Tests: Please list any previous evaluations/tests.

Date	Doctor	City, State	Reason Evaluated

Medical Hospitalizations: Please list any medical hospitalizations you have experienced.

Date	Hospital Name/Location	Reason Hospitalized

Medical History

Please note if you have any of the diseases/conditions below and date diagnosed. Provide details about the disease/condition on a separate sheet. Also, note if any of your relatives have these diseases.

	Self (Date Diagnosed)	Relative
diabetes		
heart disease		
high cholesterol		
high blood pressure		
cancer (type_____)		
chemotherapy/radiation		
hormonal problems		
lung/breathing problems		
near drowning		
anemia		
HIV/AIDS		
liver problems		
kidney problems		
severe allergic reactions		
high fever (>104 degrees)		
electric shock		
birth/developmental problems		
epilepsy		
senility/dementia		
stroke		
TIA		
AVM		
traumatic brain injury/concussion		
loss of consciousness		
Lyme Disease		
meningitis		
encephalitis		
toxic exposure		
brain cyst/growth		
other		

Please place a check in the space before the symptoms that apply to you. Provide additional details on a separate sheet, as appropriate:

Physical Symptoms

_____ Difficulty Walking

_____ Balance Problem/Dizziness

_____ Reduced Strength (Weakness) Where?

_____ Tremor/Abnormal Movements

_____ Reduced Sense of Touch Where?

_____ Hearing Problems

_____ Ringing in Ears

_____ Vision Problems

_____ Double Vision

_____ Reduced Sense of Smell

_____ Reduced Sense of Taste

_____ Pain Problems Where?

_____ Headaches

_____ Continence Problems

_____ Sexual Dysfunction

Other:

Cognitive Symptoms

_____ Memory Problems

_____ Speech/Language Problems

_____ Attention/Concentration Difficulty

_____ Processing Speed Difficulty

_____ Problem Solving Problems

Other:

Emotional Symptoms

_____ Depression/Sadness

_____ Self-Destructive Feelings

_____ Anxiety/Nervousness

_____ Anger/Irritability

_____ Bizarre/Strange Feelings

Other:

Daily Functioning

Please note (using the 1-to-10 scale below) how much assistance you **now** require to perform the following daily tasks by placing the appropriate number in the **left** space provided. Check the N/A space if the item is not applicable (e.g., you never did these things for yourself)**:**

Independent **Moderate Assist** **Maximum Assist**

|---|---|---|---|---|---|---|---|---|---|

1 2 3 4 5 6 7 8 9 10

Current Rating		**N/A**
_____	**Basic ADL's** (e.g., dressing, bathing, feeding, etc.)	_____
_____	**Complex ADL's** (e.g., meal planning, trip planning, etc.)	_____
_____	**Money Management** (e.g., paying bills, balancing checkbook, etc.)	_____
_____	**Medication Management**	_____
_____	**Driving**	_____

Habits

** Alcohol **

Do you drink alcohol? Y N If no, did you drink alcohol in the past? Y N

What is your average current alcohol consumption (i.e., list average number of drinks per day, week, etc.)?_____ Preferred drink (including size) _____

Was there a time when your alcohol consumption was heavier than present? Y N

Have you had problems due to your alcohol consumption (e.g., injuries, legal problems, family conflicts, etc.)? Y N

Have you ever experienced withdrawal symptoms after stopping use of alcohol (e.g., sweats, shakes, hallucinations, etc.)? Y N

Have you ever had a blackout (i.e., unable to recall a period of time when you had been using alcohol)? Y N

Is there a history of alcohol abuse in your family? Y N

Have you been involved in alcohol treatment? Y N

** Illicit Drugs **

Do you use illicit/street drugs? Y N If no, did you use drugs in the past? Y N

Check all that you have used:

_____ Marijuana/hashish _____

_____ Amphetamines (e.g., speed) _____

_____ Cocaine/crack _____

_____ Hallucinogens (e.g., LSD, mushrooms, etc.) _____

_____ Inhalants (e.g., nitrous oxide, glue, etc.) _____

_____ Opiates (e.g., heroin, morphine, etc.) _____

_____ Designer drugs (e.g., Ecstasy, GHB, etc.) _____

_____ Prescription drugs (e.g., Oxycontin, Xanax, etc.) _____

_____ Others (please list) _____

Have you ever used IV drugs? Y N

Have you ever over-dosed on drugs? Y N

Have you had problems from your drug usage (e.g., legal problems, family conflicts, etc.)? Y N

Illicit Drugs: Continued

Is there a history of drug abuse in your family? Y N
Have you been involved in drug treatment? Y N

** Tobacco **
Do you smoke or use smokeless tobacco? Y N Average daily use _____

** Caffeine **
Do you drink caffeinated beverages? Y N Average daily use _____

** Over-the-Counter Drugs **
Do you regularly use over-the-counter medicines (e.g., sleeping, diet, or pain drugs)? Y N
Have you ever used performance-enhancing drugs/substances (e.g., steroids)? Y N

Mental Health History: Please list any psychiatric/psychological care you have received.

Dates	Provider Name/Location	Reason Treated

Have you ever been **psychiatrically hospitalized**? Y N If yes, complete the following:

Dates	Hospital Name/Location	Reason Hospitalized

Have you been prescribed **psychiatric medications**? Y N If yes, complete the following:

Dates	Drug Name	Reason Taken

Have you ever undergone Electroconvulsive Therapy (ECT)? Y N
Have any of your family members received treatment for psychiatric/psychological problems? Y N

Personal Information
Where were you born? _____
Circle One: Single Birth Twin Triplet Other _____
Were there any problems or complications with your birth? Y N (If yes, describe on reverse):
Difficulties with your early development (e.g., walking, talking, toileting, etc.) (Describe on reverse):

Family of Origin

	Age (or age at death)	Education	Primary Job	Health
Father				
Mother				
Siblings				

Current Marital Status _____ List dates of marriage/divorce:

Children

Name Gender (M/F) Age Health

_____
_____
_____
_____

Religious Denomination _____

List your recreational interests or hobbies you enjoy. If appropriate, describe how these have been affected by your medical situation.

Education

Highest grade/degree completed in school _____ Year graduated _____

List the colleges, technical, and/or vocational schools you have attended (list most recent first):

Name Years attended Major/primary area of study

_____
_____
_____

(continue on other side, if necessary)

What were your academic strengths in school?

What were your academic weaknesses in school?

Were you ever held back any grades? Y N If so, what grades were you retained? _____
Were you ever diagnosed as having a learning disability? Y N
If you had difficulty in school, describe any special assistance or help you received:

Describe any behavior problems you had in school:

List any extracurricular school activities in which you participated (e.g., sports, clubs, etc.):

What are your plans for education in the future?

Employment

Are you currently employed? Y N If not, when did you last work? _____

List your work history beginning with your current job and going backwards:

Occupation	From	To	Reason for Leaving

(continue on a separate sheet, if necessary)

Which of these jobs was your most significant?

If relevant, describe how your current illness has affected your ability to work:

What are your future employment plans?

Compensation/Litigation: Circle one for each.

Do you currently receive Social Security Benefits?	Yes	No
Do you currently receive Worker's Compensation Benefits?	Yes	No
Are you currently receiving any disability compensation as a result of your illness?	Yes	No
Are you currently receiving disability compensation for past illnesses?	Yes	No
Are you currently involved in a lawsuit or other legal action?	Yes	No

Current Attorney: Please list the names of any legal counsel that are currently assisting you.

Name	**City, State**	**Phone**	**Reason**