PERSONAL HISTORY QUESTIONNAIRE

Here are several pages of questions that we want you to answer about yourself. Please answer them to the best of your ability, as completely and honestly as you can. Completing this information now will save a great deal of time during your evaluation!

Name _____ Today's date _____

Mailing address _____

Home phone _____ Cell phone _____ Work phone _____

Email _____

You may get help with this questionnaire if you need it, because we are interested in having complete and accurate information.

Helped by _____ Relationship _____

Person to be notified in case of emergency:

Name _____ Phone _____ Relationship _____

Are you your own guardian? Y / N **Does someone hold Power of Attorney for you?** Y / N

Name of guardian (or person with POA) _____ Phone _____

Name and address of family physician _____

_____

How did you learn of North Shore Neuropsychology / North Shore Memory Clinic?

Physician referral Friend or Family Member Web search Other _____

What is your understanding of the reason for this examination? _____

_____

Do you have a disability or special need for which you require accommodation for this examination, such as severe visual or hearing problems, severe pain, problems with mobility, severe fatigue, etc.? Please describe:

_____

_____

GENERAL INFORMATION:

Date of Birth_____ Age_____ Gender M / F Hand dominance ___ First language _____

Marital status _____ Spouse/partner's first name _____ How long married/together?____

Children (#, ages) _____

Place of birth _____ Where did you spend most of your growing-up years? _____

If you immigrated to Canada, what year was that? _____

Why did you move to Canada? _____

FAMILY HISTORY:

Father: Present age_____ Yrs of Education _____ Occupation_____ Hand he writes with___

(If deceased, age at death_____ Cause of death_____)

Mother: Present age_____ Yrs of Education _____ Occupation_____ Hand she writes with__

(If deceased, age at death_____ Cause of death_____)

Siblings: first names and present ages _____

Was there much conflict, abuse or dysfunction in your family when you were growing up? _____

Please describe briefly _____

Have *close relatives* (parent, sibling, your children) had any of the following chronic or serious medical problems? If so, indicate who:

❑ Cancer	❑ Lung disease / asthma	❑ Dementia	❑ Alcohol/drug abuse
❑ Diabetes	❑ Multiple sclerosis	❑ Anxiety	❑ Intellectual disability
❑ Thyroid problems	❑ Epilepsy / Seizures	❑ Depression	❑ Learning disability
❑ Heart problems	❑ Stroke	❑ Bipolar disorder	❑ ADD / ADHD
❑ High blood pressure	❑ Huntington's / other genetic disorder	❑ Schizophrenia	

❑ Other _____

EDUCATION HISTORY:

Circle highest year of elementary/secondary school you *completed*: 1 2 3 4 5 6 7 8 9 10 11 12

College: 1 2 3 4 Masters _____ Doctoral _____ Professional _____

Any trouble learning to read?_____ Write? _____ Do math? _____ Receive special services? _____

If yes, what for? _____

Repeat any grades? _____ If yes, which ones? _____ Year left or graduated High School_____

College/university attended _____ Major _____

Grade average _____ Year left/graduated _____

College/university attended _____ Major _____

Grade average _____ Year left/graduated _____

Additional education (e.g., technical school, specialized training, etc.)_____

_____

_____

WORK HISTORY:

What is your occupation or usual type of work? _____

For how many years?_____

Present or most recent job: Title/job description_____

Employer_____ Dates worked there_____

Reason for leaving (if not working now)_____

Previous job: Title/job description_____

Employer_____ Dates worked there_____

Reason for leaving (if not working now)_____

Previous job: Title/job description_____

Employer_____ Dates worked there_____

Reason for leaving (if not working now)_____

Previous job: Title/job description_____

Employer_____ Dates worked there_____

Reason for leaving (if not working now)_____

Did/do you generally enjoy your work? Yes No Did/do you get positive job evaluations?_____

Any particular problems at work? Yes No Please specify _____

_____

_____

If you are not working now, give reason _____

MILITARY SERVICE:

Branch of military_____ #Years served_____ Dates: _____

Highest rank _____ See combat?_____ Type of discharge_____

Job in military _____ Any problems? _____

LEGAL HISTORY:

Ever been arrested? ____ When?_____ What for? _____

Have you ever been convicted of a felony?_____ Ever serve time in jail or prison? _____

Are you currently involved in any lawsuits or legal actions? _____ Specify _____

MEDICAL / MENTAL HEALTH HISTORY:

Check any of the following that <u>you</u> have had. Please also give date or approximate age when it began or was diagnosed.

❑ Cancer	❑ Lung disease / asthma	❑ Parkinson's disease	❑ Schizophrenia
❑ Diabetes	❑ Sleep apnea	❑ Depression	❑ Learning disabilities
❑ Thyroid problems	❑ Multiple Sclerosis	❑ Anxiety	❑ ADD/ADHD
❑ Heart problems	❑ Epilepsy / seizures	❑ PTSD	❑ Abuse or severe neglect
❑ High blood pressure	❑ Dementia / MCI	❑ Bipolar Disorder	❑ Other_____

❑ Head injury with loss of consciousness. Please describe (date, circumstances) _____

_____

_____

❑ Drug/alcohol abuse. Please describe_____

_____

❑ Stroke, brain tumor, or brain infection (meningitis or encephalitis). Please give approximate date and general details _____

❑ Major surgery for _____

_____

❑ Allergies:_____

❑ Treatment for emotional problems. What were you treated for?_____

_____

What kind of treatment? (please circle all that apply) Medications / Counseling / Hospitalization

If hospitalized, please give details (when, where)_____

_____

Name of current psychiatrist and/or therapist _____

❑ Other medical or psychiatric issues _____

Give name(s) of doctors seen in last 6 months and any involved agencies:

Doctor's name_____ Specialty_____

Doctor's name_____ Specialty_____

Doctor's name_____ Specialty_____

Agency _____

Agency _____

Please list all medications that you currently take (prescribed or over-the-counter):

Medicine	For (illness)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

[Write on back if necessary to list all medications]

CURRENT SUBSTANCE USE:

Number of cigarettes you smoke / day_____ How many years have you smoked?_____

If you quit smoking, when was that? _____

Typical amount of alcohol you now consume in one day / week / year: _____ What type?_____

Any recreational drugs used now?_____ What type?_____

ACTIVITIES OF DAILY LIVING:

Have you experienced difficulties in any of the following areas of functioning in the last 6 months? If yes, check:

❑ Eating ❑ Daily hygiene ❑ Getting dressed ❑ Bathing ❑ Speech/Communication
❑ Socializing ❑ Cleaning ❑ Cooking ❑ Shopping ❑ Handling money/finances
❑ Reading ❑ Writing ❑ Using phone ❑ Using computer ❑ Using equipment/tools
❑ Walking ❑ Going up or down stairs

Details:_____

_____

Do you drive a motor vehicle? _____ Any problems driving?____ Explain _____

_____

LIFESTYLE FACTORS:

What types of activities do you participate in for fun?

_____ How often? _____x per day / week / month / year
_____ How often? _____x per day / week / month / year
_____ How often? _____x per day / week / month / year
_____ How often? _____x per day / week / month / year
_____ How often? _____x per day / week / month / year

Do you participate in any volunteer or community activities? _____

_____

Have you had to change or cut back the activities you enjoy doing? Yes / No

If so, why? _____

Do you regularly attend social functions? Yes / No

Do you regularly spend time with friends? Yes / No

Do you exercise regularly? Yes / No

If yes, what do you do?_____

If no, why not?_____

How would you rate the nutritional quality of your diet, on a scale of 1 to 5, where 1 is the worst and 5 is the best?

1 2 3 4 5

ADDITIONAL INFORMATION: Please give any other information about yourself that you think is important for us to know.

_____

_____

_____

_____

_____

PROBLEM CHECKLIST

Please carefully review the following list of problems. If any of them apply to you ***currently or in the last month***, please check the level of severity (mild, moderate or severe). ***If there are no problems, leave the boxes blank.***

	Mild Problem	Moderate Problem	Severe Problem	Comments
SLEEP				
Falling asleep	☐	☐	☐	_____
Restless, poor sleep	☐	☐	☐	_____
Nightmares	☐	☐	☐	_____
Getting up in morning	☐	☐	☐	_____
ENERGY / FATIGUE				
Too much energy	☐	☐	☐	_____
Low energy/stamina	☐	☐	☐	_____
APPETITE / WEIGHT				
Not eating enough	☐	☐	☐	_____
Eating too much	☐	☐	☐	_____
Weight (over/under)	☐	☐	☐	_____
Poor food choices	☐	☐	☐	_____
BOWELS / BLADDER				
Accidents/"soiling"	☐	☐	☐	_____
Diarrhea/constipation	☐	☐	☐	_____
PAIN				
Frequent or severe pain	☐	☐	☐	*Where?* _____
Headaches	☐	☐	☐	_____
Joint pain	☐	☐	☐	_____
Back pain	☐	☐	☐	_____
Other	☐	☐	☐	_____
HEARING				
Hard of hearing	☐	☐	☐	_____
Overly sensitive	☐	☐	☐	_____
VISION				
Poor acuity/blurriness	☐	☐	☐	_____
Light sensitivity	☐	☐	☐	_____
BALANCE/COORDINATION				
Using tools/utensils	☐	☐	☐	_____
Dizziness/vertigo	☐	☐	☐	_____
Balance	☐	☐	☐	_____
Walking	☐	☐	☐	_____
SEXUAL				
Dysfunction/pain	☐	☐	☐	_____
Problematic behaviors	☐	☐	☐	_____

	Mild Problem	Moderate Problem	Severe Problem	Comments
MEMORY				
Recalling old information	☐	☐	☐	
Recalling new information	☐	☐	☐	
Recalling names	☐	☐	☐	
Remembering dates, events, appointments	☐	☐	☐	
Remembering what I read	☐	☐	☐	
Losing things	☐	☐	☐	
ATTENTION / CONCENTRATION				
Staying focused on task	☐	☐	☐	
Distractible	☐	☐	☐	
Needing repetition	☐	☐	☐	
Completing tasks/projects	☐	☐	☐	
SPEECH / LANGUAGE				
Thinking of words, names	☐	☐	☐	
Expressing thoughts	☐	☐	☐	
Understanding conversation	☐	☐	☐	
Pronunciation	☐	☐	☐	
EXECUTIVE				
Difficulty organizing belongings	☐	☐	☐	
Difficulty organizing tasks	☐	☐	☐	
Can't make decisions	☐	☐	☐	
Procrastinate	☐	☐	☐	
Difficulty with changes	☐	☐	☐	
Problems getting started on tasks	☐	☐	☐	
SCHOOLING [current students]				
Reading	☐	☐	☐	
Writing	☐	☐	☐	
Math	☐	☐	☐	
Taking notes	☐	☐	☐	
Attendance	☐	☐	☐	
Taking tests	☐	☐	☐	
Larger projects (such as reports, term papers)	☐	☐	☐	
WORK				
Poor evaluations	☐	☐	☐	
Conflict with supervisors	☐	☐	☐	
Conflict with co-workers	☐	☐	☐	
Productivity, speed	☐	☐	☐	
Stress at or about work	☐	☐	☐	
SOCIAL				
Verbal conflict with others	☐	☐	☐	
Physically aggressive	☐	☐	☐	
Choices of friends	☐	☐	☐	
Gullible, easily influenced	☐	☐	☐	
Shy	☐	☐	☐	
Isolated, lonely	☐	☐	☐	

	Mild Problem	Moderate Problem	Severe Problem	Comments
Impulsive, disinhibited	☐	☐	☐	
Making/keeping friends	☐	☐	☐	
Marriage/partnership	☐	☐	☐	
EMOTIONAL				
Anger/irritability	☐	☐	☐	
Depression	☐	☐	☐	
Anxiety, worry	☐	☐	☐	
Fears, phobias	☐	☐	☐	
Feelings of inferiority	☐	☐	☐	
Moody, ups & downs	☐	☐	☐	
Suicidal thoughts	☐	☐	☐	
Hallucinations	☐	☐	☐	
Unusual thoughts (delusions, paranoia)	☐	☐	☐	
UNUSUAL OR REPETITIVE BEHAVIOURS				
Odd mannerisms or habits	☐	☐	☐	
Tics	☐	☐	☐	
Obsessive or compulsive behaviours	☐	☐	☐	
Hoarding	☐	☐	☐	
Unusual movements (e.g., rocking, hand flapping)	☐	☐	☐	

COMMENTS: Please describe any other problems you experience that are not listed above.

_____

_____

_____

_____

_____

_____

THANK YOU!!

Please bring this completed questionnaire with you to your appointment at North Shore Neuropsychology / North Shore Memory Clinic. If you have any questions, please call us at 604-900-1942 or email us at info@northshoreneuropsych.com.