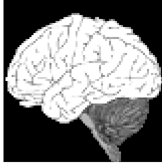
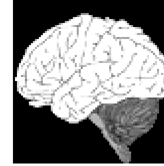


Joseph F. Kulas, Ph.D., ABPP
Board Certified
Clinical Neuropsychologist



The Exchange
Suite 344
270 Farmington Avenue
Farmington, Connecticut 06032

Phone: (860) 805-8527
Fax: (203) 271-2320
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