PATIENT NAME:

M.R. NUMBER:

# PRE-VISIT QUESTIONNAIRE

## *INSTRUCTIONS FOR COMPLETING*

*Please answer the following questions about your health and history. Although this form is lengthy, it is designed to be very thorough. Completing this information before your appointment will greatly assist the doctor to best use your assessment time with her /him by enabling a more detailed focus.*

Name of Patient: ________________________________ Date of Evaluation: ____________________

**If form not completed by patient, name of person completing & relationship to patient:**

__________________________________ NAME

__________________________________ RELATIONSHIP TO PATIENT

______________________________ PHONE NUMBER

## DEMOGRAPHICS

STREET:______________________________________________________ APT: ___________

CITY: ______________________________________ STATE __________ ZIP: _____________

PHONE (Home): ______________________________ Cell:______________________________

DATE OF BIRTH: ___________________________ AGE:_______ yrs

SEX: o Male o Female HANDEDNESS: o Right o Left o Ambidextrous

Ethnicity origin (or Race): Please circle your ethnicity.

Native American Asian African American Caucasian

Hispanic Other

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Who is your primary doctor? Dr. _______________________________________

Address: __________________________________________________________________________

Phone number: ( ) __________________________

Fax Number: ( ) __________________________

May we contact your physician? Yes No

**REFERRAL INFORMATION**

Who referred you to the Thomson Memory Center? __________________________________________

- If referred by a specific physician, mental health care provider, or other specialist, please provide his/her name, specialty and contact information below:

  Name: ______________________________ Specialty: __________________________________

  Address: ________________________________________________________________________

  Phone number: ( ) ____________________

  Fax number: ( ) ____________________

**PRESENTING PROBLEM**

Please briefly describe what problem(s) with thinking you are experiencing:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

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Did these changes have an abrupt onset (for example, normal one day and then problems the next)? Yes No

Did these changes have a gradual onset (for example, slowly negatively progressing over time)? Yes No

Please describe how long the patient has been experiencing these problems and a brief description of the course (for example, gradual onset starting 3 years ago but a more noticeable decline in the past 6 months).

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Have you noticed any of these additional symptoms? Please check those that apply to you.

A. Attention

- o Easily distracted
- o Difficulties staying on task
- o None of the Above

B. Memory

- o Ask same question repeatedly
- o Difficulties with making or keeping appointments
- o Forgetting recent conversations
- o Forgetting why you went into room
- o Forgetting where things are in the kitchen
- o None of the Above

C. Language

- o Trouble summoning words (the word feels like it is on the tip of your tongue)
- o Stopped reading
- o Mispronounce or use wrong words
- o Handwriting has deteriorated
- o Trouble recalling names of long time acquaintances
- o None of the Above

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D. Visuospatial function

- o Confused or disoriented in stores or malls
- o Getting lost easily even on familiar routes
- o Trouble finding the car in the parking lot
- o Difficulty driving: number of accidents and when:
- o None of the Above

E. Executive Function

- o Feeling unorganized
- o Lacking motivation
- o Personality changes
- o Embarrassing or inappropriate in social gatherings
- o Difficulties with hygiene-bathroom use
- o Difficulties with negative evaluations at work
- o None of the Above

F. Vision

- o Blurred vision
- o Groping for door handles
- o None of the Above

G. Emotional

- o Sadness
- o Anxiousness
- o Social problems
- o None of the Above

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# PRE-VISIT QUESTIONNAIRE

What are your typical daily activities? Please respond below.
Would you consider these activities a change from what you used to do? Yes No

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

## PAST MEDICAL HISTORY

To your knowledge, any complications with pregnancy, labor, deliver, or early development? Yes No

If yes, lease explain.

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Please check all medical conditions that you have or have had in the past:

I. EYE & EAR PROBLEMS

a) O Cataracts
b) O Glaucoma
c) O Macular degeneration of the eye
d) O Hearing loss/hearing aid
e) O Other, specify: _____________

II. HEART PROBLEMS

a) O Heart attack: year_________
b) O Heart failure
c) O High blood pressure
d) O Irregular heartbeats (arrhythmias)
e) O Aortic stenosis
f) O Other, specify: ______________

III. LUNG PROBLEMS

a) O Asthma
b) O Bronchitis
c) O Emphysema
d) O COPD
e) O Other, specify: _____________

IV. BONE & JOINT PROBLEMS

a) O Arthritis
b) O Osteoporosis
c) O Gout
d) O Fracture (circle which one(s)) hip/wrist/spine
e) O Other, specify: ______________

V. GLAND PROBLEMS

VI. KIDNEY & URINARY TRACT

a) O Diabetes
b) O Thyroid (overactive/high)
c) O Thyroid (underactive/low)
d) O Other, specify: _____________

PROBLEMS

a) O Kidney disease
b) O Prostate disease
c) O Frequent bladder or kidney infections
d) O Urinary incontinence
e) O Other, specify: _____________

VII. GASTROINTESTINAL PROBLEMS

a) O Ulcers
b) O Heartburn/hiatal hernia
c) O Diverticulosis
d) O Liver disease/Cirrhosis
e) O Hepatitis
f) O Polyps
g) O Gallbladder disease
h) O Other, specify: ___________________

VIII. NERVOUS SYSTEM PROBLEMS

a) O Stroke
b) O Dementia or Alzheimer's
c) O Parkinson's Disease
d) O Epilepsy or Seizures
e) O Exposure to toxins
f) O Head Injury (# of occurrences) ____________
Dates: _________________
g) O Other, specify: ___________

IX. OTHER HEALTH PROBLEMS

a) O Allergies (specify): _______________
b) O High Cholesterol
c) O Anemia
d) O Hernia
e) O Thrombosis (blood clots)
O of leg O of lung
f) O Sleep Apnea
Treatment: ______________________
g) O Cancer (of what): _________
h) O Psychiatric problems:
O anxiety O depression
O psychosis O bipolar
O other: _______________
i) O Sexual function problems (specify): _______________

X. RECENT MEDIAL SYMPTOMS

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a) O Loss of consciousness or near fainting
b) O Dizziness
c) O Migraines
d) O Changes in smell or taste
e) O Hallucinations
f) O Changes in appetite
g) O Loss of urine or getting wet
h) O Numbness or arm/leg weakness
i) O Sleep problems (specify):
   O Falling asleep
   O Staying asleep
j) O Tremor or Shaking
k) O Problems with falling or loss of balance

List surgeries (operations). Use additional page, if needed.

| SURGERY | DATE |
|---|---|
| 1. | |
| 2. | |
| 3. | |

List Other Hospitalizations. Use additional page, if needed.

| HOSPITALIZATION REASON | DATE |
|---|---|
| 1. | |
| 2. | |

List any neuroimaging (e.g., CT scan, MRI of the head/brain). Use additional page, if needed.

| NEUROIMAGING TECHNIQUE | DATE | ORDERING PHYSICIAN |
|---|---|---|
| 1. | | |
| 2. | | |

**PREVIOUS EVALUATIONS**

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## PRE-VISIT QUESTIONNAIRE

A. Have you ever received any of the following evaluations: psychological, neuropsychological, educational, speech/language, neurological or any other types of evaluations? (Indicated where, when and by whom these were done). Additionally, please attach copies of reports from the previous evaluations to this form.

With Whom: Date: Location: Reason for evaluation:

Did you receive early intervention services? Yes No
If yes, with whom, when, for how long, where and why?

Have you ever received physical therapy? Yes No
If yes, with whom, when, for how long, where and why?

Have you ever received occupational therapy? Yes No
If yes, with whom, when, for how long, where and why?

Have you ever received speech and language therapy? Yes No

## PRE-VISIT QUESTIONNAIRE

If yes, with whom, when, for how long, where and why?

_______________________________________________

_______________________________________________

_______________________________________________

Do you have any drug allergies? No Yes: specify below

| NAME OF DRUG | REACTION |
|---|---|
| 1. | |
| 2. | |
| 3. | |

List all medicines that you use. (prescription, non-prescription & natural products)

| NAME OF MEDICATION | STRENGTH | HOW OFTEN PER DAY |
|---|---|---|
| *Example: Tylenol* | *500 mg* | *1 pill 3 times a day* |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

Do you drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?

- o Daily
- o Almost daily (4 to 6 times a week)
- o 1 to 3 times a week
- o Less than 1 time a week
- o Never

If you drink alcohol, has anyone ever been concerned about your drinking? Yes No

Have you ever sought treatment due to a drinking problem? Yes No

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# PRE-VISIT QUESTIONNAIRE

Have you ever used tobacco? Yes No

- **If "yes,"** are you now smoking? Yes No
  How many years have you smoked? ______
  How much do you smoke? (check all that apply)
  - o Cigarettes: ______ packs per day
  - o E-cigarettes/Vaping: ______ times per day

- **If you have smoked in the past but are not currently smoking,** how many years ago did you quit? ____ For how many years did you smoke? _____ How many packs per day did you smoke? ____

Have you ever used illicit/recreational drugs? Yes No

- If yes, please specify types(s) of drugs, frequency of use, and if you currently use illicit/recreational drugs.

  ____________________________________________

  ____________________________________________

  ____________________________________________

## FAMILY HISTORY

Biological family's medical/psychological history:

Mother's side of family:

| | | |
|---|---|---|
| o Learning problems | o School problems | o Attention/concentration problems |
| o Hyperactivity | o Anxiety | o Obsessive compulsive disorder |
| o Depression | o Mental handicap | o Alcoholism/drug abuse |
| o Bipolar disorder | o Seizure disorder | o Developmental disability |
| o Genetic disorder | o Head injury | o Autism/Asperger's syndrome |
| o Metabolic disease | o Diabetes | o Dementia or Alzheimer's disease |
| o Stroke | o Cancer: of what? ______ | o Other condition (specify): ____________ |

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## PRE-VISIT QUESTIONNAIRE

Father's side of family:

| | | |
|---|---|---|
| o Learning problems | o School problems | o Attention/concentration problems |
| o Hyperactivity | o Anxiety | o Obsessive compulsive disorder |
| o Depression | o Mental handicap | o Alcoholism/drug abuse |
| o Bipolar disorder | o Seizure disorder | o Developmental disability |
| o Genetic disorder | o Head injury | o Autism/Asperger's syndrome |
| o Metabolic disease | o Diabetes | o Dementia or Alzheimer's disease |
| o Stroke | o Cancer: of what? ______ | o Other condition (specify): ____________ |

**MENTAL HEALTH HISTORY**

Are you currently experiencing significant emotional distress? Yes No
If yes, please explain:

______________________________________________________________________

______________________________________________________________________

Have you ever received outpatient psychotherapy counseling? Yes No

Therapists: ____________________________________________________

Diagnoses: ____________________________________________________

Duration of treatment: ___________________________________________

Response to treatment: __________________________________________

Have you been a victim of emotional, physical or sexual abuse? Yes No
If yes, please explain:

______________________________________________________________________

______________________________________________________________________

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## PRE-VISIT QUESTIONNAIRE

Have you ever received acute psychiatric care? Yes No

Program: ______________________ Dates of attendance: ______________

Have you ever attended Residential or Day treatment programs? Yes No

Program: ______________________ Dates of attendance: ______________

Program: ______________________ Dates of attendance: ______________

Program: ______________________ Dates of attendance: ______________

Have you used in-home services? Yes No

If yes, please explain:

_______________________________________________

_______________________________________________

_______________________________________________

**SCHOOL EXPERIENCES**

| Schools Attended | Grades | Academic Concerns | Behavioral Concerns |
|---|---|---|---|
| Preschool | | | |
| Kindergarten | | | |
| Elementary School | | | |
| Middle/Junior High | | | |
| High School | | | |
| Post High School | | | |

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## PRE-VISIT QUESTIONNAIRE

Do you/did you have any studying and/or learning problems? (If yes, please describe)

______________________________________________

______________________________________________

______________________________________________

To the best of your knowledge, at what grade level are you currently performing?

Reading: _________________ Math: ________________ Writing: ________________

Have you ever been held back or has grade retention ever been suggested? Yes No
If yes, please explain:

______________________________________________

______________________________________________

Have you ever received special education services or received academic accommodations through a 504 plan? If yes, please explain:

______________________________________________

______________________________________________

Have you received private academic tutoring? Yes No
If yes, with who, how often, when did it begin and what is the focus?

______________________________________________

______________________________________________

As a young child, did you have difficulties completing homework? Yes No
If yes, please explain:

______________________________________________

As a young child, did you have difficulties paying attention in class? Yes No
If yes, please explain:

______________________________________________

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# PRE-VISIT QUESTIONNAIRE

As a young child, did you get in trouble in class for misbehavior? Yes No
If yes, please explain:

______________________________________________________________________

## SOCIAL HISTORY

Please check the appropriate response for each question below:

With whom do you live?

- o Alone
- o Spouse or partner
- o Child or other family member
- o Others, not family
- o Other, specify: ______________________________________________

Which of the following best describes your residence?

- o Single-family house
- o Condo or apartment
- o Live with family members
- o College dorms
- o Other, specify: ______________________________________________

Are you currently:

- o Married
- o Divorced / Separated
- o Widowed
- o Single / Never married
- o Living with Significant Other

Did you or your spouse serve in the military? Yes No

How many children do you have? _______
Are you in regular contact with your children? Yes No

How much school did you complete?

- o Less than 6th grade
- o Less than high school graduate
- o High school graduate
- o Some college
- o College graduate
- o More than college graduate

Total number of educational years: ____

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## PRE-VISIT QUESTIONNAIRE

Did you attend trade school? Yes No
Specify trade: ____________________

Is English your primary language? Yes No
If no, what is your first language? ______________________________

Did you go to school in the United States? Yes No
If no, where? ______________________________

Were any subjects more difficult than the others? Which ones? ________________________

Did you fail any grades? ______________________________

What is/was your principal occupation? ______________________________

Are you currently:
- o Retired / not working when: ____________________
- o Working part-time
- o Working full-time

Do you have any additional information that you would like the doctor to know about before your visit?

Yes No

______________________________

______________________________

______________________________

**EMERGENCY CONTACT**

NAME: ______________________________ RELATIONSHIP: ____________________

PHONE (Home): ______________________________ Cell: ______________________________

*Thank you for your cooperation and patience in completing this form!*