ADULT HISTORY QUESTIONNAIRE

MONTANA NEUROPSYCHOLOGICAL ASSOCIATES
1622 South Avenue West
Missoula, MT 59801
(406) 543-9700

IDENTIFYING INFORMATON

Date: _____

First Name: _____ Last Name: _____
Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone : _____

Gender Assigned at Birth: _____ Male _____ Female
Preferred Gender/Currently Identify: _____ Male _____ Female ____ Non-Binary ____ Other
Preferred Pronouns (i.e., he/him; she/her; they/them): _____

Race:
_____ Caucasian/White _____ African American
_____ Native American _____ Asian
_____ Hispanic _____ Other: _____

Marital Status:
____ Married ____ Divorced ____ Single ____ Other

Name of Partner/Significant Other: _____

Name(s) and Age(s) of Children: _____

Years of Education (grade completed, e.g., 10th, High School, College): _____

Emergency Contact: _____ Phone Number: _____
Referral Source: _____

Have you been evaluated in our clinic in the past? _____ Yes _____ No
If yes, when? _____

Do you currently use the following:
Glasses/Contacts _____ Yes _____ No
Hearing Aids _____ Yes _____ No
If yes: _____ Left _____ Right _____ Bilateral

CURRENT CONCERNS

Please briefly describe the specific problem(s) you would like addressed with the evaluation:

MEDICAL HISTORY

Please indicate if you have ever been diagnosed and/or had difficulties with any of the following:

	Yes	No	Date Diagnosed/Please Describe
ADD/ADHD			
Allergies			
Anxiety Disorder			
Asthma			
Bipolar Disorder			
Cardiovascular Problems			
Chronic Pain			
Depression			
Diabetes			
Dizziness			
Eating Disorder			
Gastrointestinal Problems			
Head Injury/Concussion			
Headaches			
Hospitalization (date & reason)			
Hypertension			
Learning Disabilities			
Loss of Consciousness			
Meningitis/Encephalitis			
Motion Sickness			
Ocular/Vision Problems			
Oxygen Deprivation (Anoxia)			
PTSD			
Seizures/Epilepsy			
Self Harm Behaviors/Suicide Attempts			
Sleep Apnea or Sleep Difficulties			
Stroke			
Surgeries			
Toxic Exposure/Overdose			
Vertigo			
Other (specify)			

List all medications (prescription medications and over-the-counter medications you are currently taking:

Date Prescribed	Medication	Dose	Prescribed By

List all prescription medications you have taken in the past:

Medication	Dose	Reason Discontinued

PREVIOUS CONSULTATIONS/EVALUATIONS/SERVICES

Please indicate if you have ever undergone evaluations for the following:

	Yes	No	Dates	Diagnosis/Results
Neurological				
Neuropsychological				
Psychological				
Counseling/Therapy				
Mental Health Hospitalization				
Other (specify)				

Have you ever had a **brain scan (**MRI, CT scan or EEG)? _____ Yes _____ No

If yes:

Date	Where	Type	Ordered By	Results

DEVELOPMENTAL HISTORY

Are you aware of your mother experiencing any problems/difficulties with your pregnancy and/or birth? _____ Yes _____ No

If yes, please explain:

As far as you know, did you meet developmental milestones (crawling, walking, talking, etc.) on time? _____ Yes _____ No

If no, please explain:

FAMILY HISTORY

Please indicate if any blood relatives have been diagnosed with any of the following. Also indicate whether from maternal (M) or paternal (P) side of the family and which member(s) have the diagnosis (i.e., grandmother).

	Yes	No	M	P	Family Member (mother, aunt, cousin, etc.)
ADD/ADHD					
Alzheimer's Disease/Dementia					
Anxiety Disorder					
Autism/Asperger's Disorder					
Bipolar/Manic Depression					
Cancer					
Chronic Headaches/Migraines					
Depression					
Diabetes					
Drug/Alcohol Abuse					
Epilepsy/Seizures					
Heart Trouble					
High Blood Pressure					
Huntington's Disease					
Hyperactivity					
Learning Difficulties (specify)					
Multiple Sclerosis					
Nervous Breakdown					
Obsessive-Compulsive Disorder					
Parkinson's Disease					
Personality Disorder					
Schizophrenia/Psychosis					
Sleep Disorder/Apnea					
Stroke					
Thyroid Problems					
Other (specify)					

EDUCATIONAL HISTORY

Do you feel that learning was difficult for you as a child? _____ Yes _____ No

If yes, how was it challenging?

Did you receive any resource and/or special education services in school? _____ Yes _____ No

If yes, for what subject(s)/reason(s):

Are you currently in school? _____ Yes _____ No

If so, where? _____

If yes, are you currently experiencing any problems/difficulties with learning? _____ Yes ____ No

If yes, how?

MILITARY HISTORY

Have you ever served in the military? _____ Yes _____ No

If yes, which branch: _____ Dates served: _____

Rank/MOS: _____

Were you ever on combat deployment(s)? _____ Yes _____ No

If yes:

Dates	Location

EMPLOYMENT HISTORY

Are you currently employed? _____ Yes _____ No

If yes, where: _____ Position: _____

If not, last place of employment: _____ Reason for leaving: _____

Have you had any problems/difficulties in your current employment and/or any previous employment? _____ Yes _____ No

If yes, please explain:

DRUG/ALCOHOL HISTORY

Please list any substances you currently use or used in the past and describe the degree of use/amount and when used last:

	Current	Past	Amount/Last Time Used
Alcohol			
Marijuana/Pot			
Cocaine			
Meth			
Heroin/Opium			
Inhalants			
Pain Medications			
Prescription Medications			
Other (specify)			

Has anyone ever commented that your use has been excessive? _____ Yes _____ No

Has your use caused significant difficulties in your employment and/or with significant others? _____ Yes _____ No

If yes to either, please explain:

Are you currently in treatment for substance use/abuse? _____ Yes _____ No

If yes, where/with whom: _____

Have you ever been in treatment for substance use/abuse? _____ Yes _____ No

If yes, when and where: _____

LEGAL HISTORY

Are you currently involved with the legal system? _____ Yes _____ No

If yes, describe circumstances:

Have you ever been involved with the legal system? _____ Yes _____ No

If yes, describe circumstances:

MISCELLANEOUS INFORMATION

If there is any other information you would like to share, please do so here: