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ARIZONA NEUROLOGY ASSOCIATES
Providing comprehensive neurological care.

Your appointment will take 2-4 hours with short breaks as needed. We strongly recommend that a family member accompany you and that they bring something to read while they wait for you. If you have small children, please make childcare arrangements if possible.

The appointment will include a brief interview with you and your family members, paper-and-pencil and computerized tests of your thinking skills, and questionnaires about your mood. If you have had a CT, MRI, EEG, or other neurologic workup including blood work or previous neuropsychological testing, please bring a copy of your results with you, or fax or mail them to us ahead of your appointment. Please also bring an up-to-date medication list. *If you use glasses or hearing aids, please bring them.* If you get lost on your way to the clinic, please call our office: 623-377-7410.

The results of your evaluation will be sent to your referring doctor approximately two weeks after you complete the assessment. You will also be scheduled for a feedback appointment during which your results will be explained to you and anyone whom you wish to bring with you.

Please answer the following questions as they apply to you. Your family or friends can help. Please note that this is a clinical evaluation. If the purpose of this evaluation relates to current or potential legal action, please have your lawyer arrange this evaluation through our administrative assistant, Crystal Duran, ahead of your appointment date.

Questionnaire completed by:_____ about (Patient's Full Name): _____

Relationship to Patient (circle all that apply): Spouse/Partner Child Sibling Friend Caregiver Power of Attorney

PATEINT BACKGROUND INFORMATION

Age:_____ Date of Birth:_____ Gender:_____ Ethnicity:_____

Native language:_____ Preferred language:_____ Marital Status:_____(years)_____

Email address:_____ Best number to reach you:_____

Handedness (circle one): Right Left Did you ever change from using one hand to the other? (YES / NO)

If left-handed, is any one else in your family (e.g., father, mother, siblings, grandparents) left-handed? (YES / NO) If so, who?:
_____

The following information will aid in our ability to provide you with the best care and treatment possible. Please answer all questions honestly and to the best of your ability.

FAMILY HISTORY: **Please indicate the age and health of your blood relatives, if known.** Please note problems such as diabetes, dementia, stroke, schizophrenia, depression, etc.

	Alive	Current Age OR Age at Death	Highest Education	Lifelong Career/Occupation	Psychiatric or Medical problems? (or cause of death if deceased)
Mother	Y/N				
Father	Y/N				
Brother(s)	Y/N				
	Y/N				

	Y/N				
Sister(s)	Y/N				
	Y/N				
	Y/N				

Please note major medical or psychiatric conditions if present/known	
Maternal Grandparents	
Maternal Aunt(s)/ Uncle(s)	
Paternal Grandparents	
Paternal Aunt(s)/ Uncle(s)	
Cousins	

Please note major medical or psychiatric conditions if present/known		
Biological child (Name)	Age	Specify problem(s):

DEVELOPMENTAL HISTORY:

Where were you born?_____ Where were you raised? _____

Were you born: on time____ prematurely___ late___ not known_____

Were there any known problems associated with your birth?_____

Please circle if you had any of the following conditions as a child:

Developmental delays	Hyperactivity	Reading Disability | Dyslexia
Seizures	Behavioral problems	Psychiatric Problems
Attention problems	Head injury	Learning Disability

LANGUAGES:

What languages do you speak fluently?_____
What language do you speak in the home? _____

EDUCATIONAL BACKGROUND:

What is the highest grade/degree you completed? _____

Did you fail/skip any grades? (YES / NO) If so, which grades?_____

Best subject(s)/grades:_____Worst subject(s)/grades:_____

Did you attend any special education classes/have an IEP?_____

If you left high school before graduation, why?: _____ GED? Y/N

Please complete information about any further schooling, if applicable:

Undergraduate	Name of University	Years attended	Major	Degree Obtained
Graduate School	Name of University	Years attended	Major	Degree Obtained

WORK HISTORY:

If you are currently working, what is your occupation/job title?_____

What company/organization do you work for?_____

Have you had difficulty working because of problems with your thinking or mood? (YES / NO) If yes, please explain:_____

_____

If retired, at what age did you retire and for what reason?_____

Please list jobs you held in the past (starting with the most recent)

Position	Duties/Responsibilities	From (year) to (year):

Have you ever served in the military?: (YES / NO) If yes, division and highest rank: _____
Overseas deployment?: (YES / NO) If yes, please describe: _____

PERSONAL/SOCIAL HISTORY:

Current marital status: Married:____ Single:_____ Divorced:____ Widowed:_____ Separated:____

Years married to current spouse/partner:_____ Number of times married:_____

Partner's occupation:_____ Partner's major health problems:_____

What type of home do you live in?: House Apartment/Condo Assisted Living Facility
Who lives in the home with you?: _____

Are you physically active?: (YES / NO) Please describe: _____
Are you socially active?: (YES / NO) Please describe: _____

PAST AND CURRENT MEDICAL CONDITIONS: Please circle if you had any of the following conditions:

Arthritis	Incontinence	Mild Cognitive Impairment
Obstructive Sleep Apnea	Hypertension	Dementia
Hypo/Hyperthyroidism	Myocardial Infarction (Heart Attack)	Parkinson's Disease/Essential Tremor
Vitamin D or B12 Deficiency	Coronary Artery Disease	Epilepsy/Seizure
COPD	Headaches (Tension, Migraine, Cluster)	Transient Global Amnesia
Diabetes Mellitus (Type I or II)	Brain Aneurysm/Tumor/Abscess	Multiple Sclerosis
Neuropathy/Peripheral Numbness	Valley Fever/Lyme's Disease	Encephalitis/Meningitis
Pain	Cancer (Chemotherapy/Radiation)	Neurosurgery
Chronic Fatigue	HIV/AIDS	Surgeries with General Anesthesia
Frequent Falls	Insomnia	
Vision/Hearing Problems		

Have you ever had neuroimaging (CT/MRI/SPECT/PET) of your head/brain?: (YES / NO) If yes, why and when: _____

_____

Have you ever had an EEG?: (YES / NO) If yes, why and when: _____

Please list any illnesses or conditions you receive(d) treatment for not listed above:

Medical problem(s)/Hospitalizations	Onset/Date	Current
		Y/N
		Y/N
		Y/N
		Y/N

Have you ever been exposed to toxins or heavy metals?: (YES / NO) If yes, please describe: _____

Have you ever had a head injury with loss of consciousness?: (YES / NO) If yes, when: _____

Have you ever had a seizure?: (YES / NO) If yes, when: _____

Have you haver had a TIA/stroke?: (YES / NO) If yes, when: _____

On average, how many hours of sleep do you get nightly?: _____

Please describe your sleep quality: Restorative/Restful Non-restorative/Restless Active

How many hours did you get the night before this evaluation?: _____

PAST AND CURRENT PSYCHIATRIC CONDITIONS: Please circle if you had any of the following conditions:

Depression	Post-Traumatic Stress Disorder	Personality/Behavioral Changes
Anxiety	Bipolar Disorder	
Panic Attacks	Schizophrenia	
Obsessive-Compulsive Disorder	Personality Disorder	
Attention Deficit-Hyperactivity Disorder	Hallucinations or Delusions	

Have you ever been under the care of a mental health provider?: (YES / NO) If yes, please describe: _____

_____

Are you currently seeing a licensed social worker/psychologist/psychiatrist?: (YES / NO) If yes, please describe: _____

_____

SUBSTANCE HISTORY:

Do you currently smoke or use tobacco? yes____ no____ If yes, how much? _____ pack/day since:_____

If you previously smoked, when did you stop?_____

Do you drink alcohol? yes____ no____ If yes, on average, how much and what?_____

If you used alcohol in the past, when did you stop?_____ Were you ever a heavy drinker? yes____ no____

Have you ever used any illicit drugs? yes____ no____ If yes, which one(s)? _____

MOOD: How would you describe your mood over the past month? Examples include: "very good, average, a bit down, depressed at times, very depressed, anxious, angry, irritable"_____

Do you tend to worry a lot?_____

Do you feel capable of making decisions about things?_____

HISTORY OF CURRENT PROBLEMS:

What are the most important problems that prompted this evaluation?

1.
2.
3.

When did these problems **start**?_____ Did they start **gradually** or **abruptly**?

Are they **still present**? (YES / NO) Are they getting better, worse, or staying the same?_____

Please provide an example if possible_____

_____

_____

_____

_____

Other relevant problems:_____

_____

_____

Do you currently drive? yes____ no____

If not, when did you stop driving, and why?_____

Have you ever had a formal driving evaluation?_____

Is there anything you would like to discuss with us that we have not yet explicitly asked above?:

_____

_____

_____

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire.

****PLEASE BRING THIS COMPLETED QUESTIONNAIRE WITH YOU FOR YOUR APPOINTMENT****