Johnson Neuropsychology, PLLC

Geriatric Questionnaire

This form should be completed by someone who knows the patient well and spends significant amount of time with the patient to observe behaviors. Sometimes more than one person involved with the patient may collaborate together with or without input from the patient where appropriate. Please complete every question to the best of your ability or write "unknown" when applicable. Thank you!

PATIENT: ____
ADDRESS: ____________________________________
____
TELEPHONE: __________________________________
REFERRAL SOURCE: ___________________________
ETHNICITY: ____________________________________

DATE ___________________________
DATE OF BIRTH: ________________ AGE:_____
HANDEDNESS (circle one):
Right Left Ambidextrous
HIGHEST EDUCATION: ____________________
OCCUPATION (Former): ____________________

THIS FORM WAS COMPLETED BY: ____
RELATION TO PATIENT ____

What are the top five (5) symptoms or problems that you would like to see improved? (List in order from Most to Least Important)

1____
2____
3____
4____
5____

Please describe the history of the present difficulties:

____
____
____
____
____
____

When did you first notice these difficulties? ____

How much is daily life impacted? Extreme [ ] Significant [ ] Mild [ ] None [ ]

History of the following Diseases/Surgeries (check all that apply):

__________ Loss of Consciousness
__________ Concussion
__________ Stroke
__________ Convulsions
__________ Encephalitis
__________ Meningitis
__________ High Fever (over 104° F)
__________ Seizure
__________ Oxygen Deprivation or
__________Near Drowning
__________ Accidental Poisoning (specify substance)
__________ Appendectomy
__________ Cerebral Palsy
__________ Pneumonia
__________ Allergies
__________ Asthma/Bronchitis
__________ Cancer
__________ Multiple Sclerosis
__________ Broken Bones
__________Other:___________

MEDICAL HISTORY

Current medical problems:____
Past medical problems:____

Current Medications, Supplements, including Over the Counter (OTC) Medicine (e.g., Tylenol) & Dosages

Medication, Supplements, or OTC	Dose	Date started	Is it beneficial? Circle one	List any side effects
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	

Hospitalizations (when, where, why, how long?):
____
____
____

Traumas requiring medical attention (stitches, fractured bones, falls, automobile accidents, etc.):
____
____
____

Any history of head trauma, concussion, loss of consciousness? Yes or No (describe): ________________________
____
Ever any seizures or seizure like activity? Yes or No ________________________
Ever any fainting spells? Yes or No________________________
Any periods of spaciness or confusion? Yes or No________________________
Prior abnormal lab tests, X-rays, EEG, etc.:________________________
Allergies/drug intolerances? Yes or No (describe):________________________
Ever been tested for food allergies? Yes or No *Describe*________________________
Ever had or suspected to have a thyroid disorder? Yes or No
Ever had or suspected to have blood sugar problems (hypoglycemia) or diabetes? Yes or No
Present Height _______ Present Weight _______
Vision (circle): Normal Corrected Changes in vision
Hearing (circle): Normal Corrected Needs to be checked

SLEEP BEHAVIOR (circle all that apply): sleepwalking nightmares recurrent dreams difficulty falling asleep wakes up during the night difficulty getting up no problems with sleep

SCHOOL HISTORY: Last grade completed ______ Did you receive a GED or high school diploma? (Circle)
Average grades received _______________ Specific learning disabilities ________________________
Learning strengths ________________________
Any behavior problems in school? ________________________
What have teachers said about you?________________________
Did you attend college or University? _____What was your major?_____________Did you graduate?_____
Name of College or University:________________________ Years attended__________________
Describe any academic problems you had in college or university.________________________
____
____

OCCUPATIONAL HISTORY: (Please list most current jobs first and then past jobs for PAST 5 YEARS.)

Job	Employer	Approximate Dates	Reason for Leaving	FT/PT

Any work-related problems?

____

____

PSYCHIATRIC HISTORY:

Please list every psychiatric diagnosis given to you by your therapist, psychologist, psychiatrist, or physician:

____

____

____

Psychiatric Hospitalizations (dates, why; was treatment helpful?)

____

____

CURRENT LIFE STRESSES (include anything that is currently stressful for the patient, examples include relationships, job, school, finances, children)____

ALCOHOL AND DRUG HISTORY:

Do you use alcohol (hard liquor, beer, wine)?.................................Yes No How often? _______________

Do you use illegal drugs…….?...Yes No How often? _______________

Do you use prescription tranquilizers or sleeping pills?..................Yes No How often? _______________

Other?..Yes No How Often? _______________ __

Do you experience withdrawal symptoms from alcohol or drugs? Yes No Withdrawal in the past? Yes No

Has anyone told you they thought you had a problem with drugs or alcohol? _________________________

Have you ever felt guilty about your drug or alcohol use? ____

Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _______________

Have you ever used drugs or alcohol first thing in the morning?____________________________________

Tobacco:

Current Use (Last 30 days): Yes No Past Use: Yes No

Length of Use: _________________________ How Much: ____________________________________

CURRENT SYMPTOMS:

Memory:

Immediate Memory problems (names, faces, telephone #)	None	Mild	Moderate	Severe
Visual Memory Problems	None	Mild	Moderate	Severe
Verbal Memory Problems	None	Mild	Moderate	Severe
Short-term Recall – Difficulty remembering newly learned experience	None	Mild	Moderate	Severe
Long-term or Remote Recall – Difficulty remembering past experiences/events	None	Mild	Moderate	Severe
Absent-Mindedness	None	Mild	Moderate	Severe
Difficulty with Old Learning - (e.g., balancing a checkbook, taking a bus, recipes, simple math or spelling)	None	Mild	Moderate	Severe
Difficulty with New Learning - (e.g., learning something new involving 3 or 4 steps)	None	Mild	Moderate	Severe
More memory problems later in the day/evening	None	Mild	Moderate	Severe

Speech:

Difficulty Expressing Thoughts	None	Mild	Moderate	Severe
Difficulty Understanding Others	None	Mild	Moderate	Severe
Change in Articulation/Slurred or Mumbled Speech	None	Mild	Moderate	Severe
Trouble Finding Correct Word or Desired Word	None	Mild	Moderate	Severe

Saying Wrong or Inappropriate Word	None	Mild	Moderate	Severe
Hesitations when speaking	None	Mild	Moderate	Severe
Substitutions when speaking (e.g., “thing”, or “stuff”)	None	Mild	Moderate	Severe
Difficulty Constructing Sentences	None	Mild	Moderate	Severe

Thought Processes:

Lacks insight or is unaware of having any problems	No	Mild	Moderate	Severe
Difficulty making decisions	None	Mild	Moderate	Severe
Trouble Organizing Thoughts or Actions	None	Mild	Moderate	Severe
Slowed Thinking	None	Mild	Moderate	Severe
Distractibility	None	Mild	Moderate	Severe
Visual hallucinations	None	Rare	Sometimes	Often
Auditory Hallucinations	None	Rare	Sometimes	Often
Delusions or Overly Suspiciousness	None	Mild	Moderate	Severe
Confusion or Disorientation	None	Mild	Moderate	Severe
Making up stories	None	Mild	Moderate	Severe
Decreased Problem Solving Ability	None	Mild	Moderate	Severe
Changes in Ability to Read or Write or Spell	None	Mild	Moderate	Severe
Changes in Ability to do Math	None	Mild	Moderate	Severe

Motor/Behavior :

Balance problems	None	Mild	Moderate	Severe
Slowed movements or slowed reaction time	None	Mild	Moderate	Severe
Loss of coordination	None	Mild	Moderate	Severe
Tremors: right hand left hand both hands	None	Mild	Moderate	Severe
Impulsiveness	None	Mild	Moderate	Severe
Aggressiveness or Violent Outbursts	None	Mild	Moderate	Severe
Inappropriate behaviors (example:____________________)	None	Mild	Moderate	Severe
Rigid movements or movements too stiff	None	Mild	Moderate	Severe
Loss of facial expression	None	Mild	Moderate	Severe
Hoarding behaviors	None	Mild	Moderate	Severe
Compulsiveness –lots of time spent doing certain activities	None	Mild	Moderate	Severe
Repetitive behaviors (counting, pacing, repeating phrases)	None	Mild	Moderate	Severe
Difficulty with familiar tasks (e.g. getting dressed, combing hair, etc.)	None	Mild	Moderate	Severe
Involuntary movements (e.g., arms, legs, head, trunk, etc.)	None	Mild	Moderate	Severe
Overly sexual or sexually inappropriate	None	Mild	Moderate	Severe
Craves sweets	None	Mild	Moderate	Severe
Increased appetite	None	Mild	Moderate	Severe
Loss of appetite	None	Mild	Moderate	Severe
Urinary incontinence	None	Mild	Moderate	Severe
Fecal incontinence	None	Mild	Moderate	Severe

Mood :

Apathy	None	Mild	Moderate	Severe
Irritability	None	Mild	Moderate	Severe
Depression	None	Mild	Moderate	Severe
Anxiety	None	Mild	Moderate	Severe
Too emotional/Overly sentimental	None	Mild	Moderate	Severe
Lack of empathy	None	Mild	Moderate	Severe
Overly religious	None	Mild	Moderate	Severe
Change in personality	None	Mild	Moderate	Severe

FAMILY HISTORY

Marital Status: Single: ________ Separated: ________ Widowed: ________
Married: ______ Divorced: ________ Same-Sex Partner: ________

Biological Mother's History: age_____ occupation ____
School: highest grade completed ____
Learning problems (specify) ____
Has mother ever sought psychiatric treatment? Yes ___ No ___If yes, for what purpose?______________

____
Has your mother or any of her blood relatives ever had any learning or psychiatric problems including ADD/ADHD, alcohol/drug abuse, depression, bipolar disorder/manic depression, anxiety, dementia, Alzheimer's, suicide attempts, or psychiatric hospitalizations?_______________________________________
(specify)____

Biological Father's History: age_____ occupation ____
School: highest grade completed ____
Learning problems (specify) ____
Has father ever sought psychiatric treatment? Yes ___ No ___If yes, for what purpose?______________
Has your father or any of his blood relatives ever had any learning or psychiatric problems including ADD/ADHD, alcohol/drug abuse, depression, bipolar disorder/manic depression, anxiety, dementia, Alzheimer's, suicide attempts, or psychiatric hospitalizations?_______________________________________
(specify)____

Siblings (names, ages, medical or mental health problems?)
____
____
____

Children (names, ages, medical or mental health problems?)
____
____

ACTIVITIES OF DAILY LIVING
Do you keep in contact with or visit friends? Yes No How often?_______________________________

Are you able to … (circle the appropriate response)

Bathe yourself	Independently	With Assistance	Unable to perform
Groom yourself	Independently	With Assistance	Unable to perform
Cook	Independently	With Assistance	Unable to perform
Shop	Independently	With Assistance	Unable to perform
Clean house	Independently	With Assistance	Unable to perform
Pay Bills	Independently	With Assistance	Unable to perform
Manage your money	Independently	With Assistance	Unable to perform
Track medications	Independently	With Assistance	Unable to perform
Drive	Independently	With Assistance	Unable to perform