PARS inc
PACHET ASSESSMENT & REHABILITATION SERVICES

ADULT NEUROPSYCHOLOGICAL QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire. The information you provide will help us assess the problems you may be having and give us important background information that is integral to our assessment. Please complete the questionnaire as accurately as possible but do not worry if you have difficulty with any sections as we will be going over these questions with you during your appointment. Please note that any information you provide during this evaluation could be included in the assessment report.

Name: _____ Email address: _____

Date of Birth: _____ Age:____ Phone #: _____

Where do you currently live? _____

Hand used for writing: [ ] Right [ ] Left [ ] Both

Are you colour-blind? [ ] Yes [ ] No

Where were you born? _____
If you were not born in Canada, when did you arrive in Canada? _____

Where were you raised? _____

First Language: _____
If English is not your first language, when did you learn how to speak English? _____
List any other languages you speak: _____

Do you require hearing aids? [ ] Yes [ ] No
If yes, do you have your heading aides with you? [ ] Yes [ ] No

Do you require reading glasses? [ ] Yes [ ] No
If yes, do you have your reading glasses with you? [ ] Yes [ ] No

Emergency contact name: _____ Phone #: _____

I) EARLY HISTORY

Were you born: [ ] Full term [ ] Premature by _____ weeks

Were there any problems during your birth or right after you were born? (e.g., prenatal stroke, abnormal brain development, lack of oxygen, unusual birth position, special equipment used, seizures, illnesses, etc.,) [ ] Yes [ ] No
If yes, please list:_____

Did your mother use alcohol or drugs during the pregnancy? [ ] Yes [ ] No [ ] Don't Know
If yes, please explain:_____

Did you have any difficulties learning how to walk or talk, or with any other developmental abilities? [ ] Yes [ ] No
If yes, please explain: _____

As a child, did you have any of these conditions? (Check all that apply):

[ ] Attention Problems	[ ] Hearing Problems	[ ] Speech Problems
[ ] Clumsiness	[ ] Learning Disability	[ ] Other: _____
[ ] Frequent Ear Infections	[ ] Muscle Tightness or Weakness	[ ] None
[ ] Head Injury		

II) EDUCATIONAL HISTORY

Did you finish high school (not including a G.E.D.)? [ ] Yes [ ] No
If no, what grade did you leave and why? _____
If no, did you subsequently complete a G.E.D.? [ ] Yes [ ] No
Date you obtained your G.E.D.: _____

What was your average mark in school?_____

What was your strong subject(s) in school? _____

What was your weak subject(s)? _____

Did you repeat any grades in school? [ ] Yes [ ] No
If yes, which one(s) and what was the reason? _____

Did you receive special assistance or were you in special classes in school? [ ] Yes [ ] No
If yes, what did you receive help for? _____

Were you ever diagnosed with a: learning disability? [ ] Yes [ ] No
: attention deficit? [ ] Yes [ ] No
: hyperactivity? [ ] Yes [ ] No
If yes to any of these, when were you diagnosed? _____

Have you completed any post-secondary education? [ ] Yes [ ] No
If yes, what type of diploma or degree did you obtain and when? _____
_____
How many years did it take you to obtain your diploma or degree? _____
Did you attend your post-secondary schooling part-time or full-time?_____
What post-secondary school(s) did you attend?_____
If you did not complete your program, why?_____

III) OCCUPATIONAL HISTORY

Are you currently working? [ ] Yes [ ] No [ ] Retired
If you are currently working, are you doing your regular job? [ ] Yes [ ] No
If no, please describe how your job duties have changed: _____
_____

If you are not working, are you on medical leave? [ ] Yes [ ] No
If you are not currently working, when did you stop working? _____

Please list any income support you are currently receiving (e.g., WCB, insurance, AISH, Alberta Works, etc.,) _____

Job title at the time of your injury/accident: _____
How long had you been in this job? _____
Employer:_____
Please briefly describe your regular job duties: _____
_____

Job History:

Previous job position:	Name of employer:	Dates of employment:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any toxic, hazardous, noxious, or otherwise dangerous substances (e.g., lead, mercury, radiation, solvents, pesticides, chemicals, etc.) you were exposed to while working:
_____

Have you ever filed a workers compensation claim? [ ] Yes [ ] No
If yes, date and reason: _____

Did you have difficulties or limitations in your job performance before this injury? [ ] Yes [ ] No
If yes, please explain: _____

Do you have any special licenses or certificates? [ ] Yes [ ] No
If yes, please list: _____

Do you have any experience working in the military? [ ] Yes [ ] No
If yes, please describe: _____

What do you do during a typical day if you are not working?_____
_____

IV) MEDICAL HISTORY

Name of your family doctor: _____
How long have you been under the care of your family doctor? _____

Please list all of your current medications:

Name of drug & dosage:	When did you start this drug?	Any major side-effects?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any surgeries? [ ] Yes [ ] No
If yes, please describe and provide dates: _____
_____

Check any and all the conditions that you have been diagnosed with PRIOR to your injury/claim. Add any helpful details (e.g. age at diagnosis, treatment provided) if the condition was serious.

[ ] AIDS, ARC, or HIV +
[ ] Allergies
[ ] Anxiety
[ ] Artery Disease
[ ] Arthritis
[ ] Asthma
[ ] Bipolar Disorder
[ ] Blood Disorder
[ ] Brain Infection/Disease
[ ] Cancer/ Chemotherapy
[ ] Cerebral Palsy
[ ] Chicken Pox
[ ] Chronic Fatigue
[ ] Chronic Pain
[ ] Colds (excessive)
[ ] Depression
[ ] Diabetes
[ ] Encephalitis
[ ] Epilepsy
[ ] Fainting Spells
[ ] Fevers (104 F or higher)
[ ] Fibromyalgia
[ ] Hazardous Substance Exposure
[ ] Heart Disease or Problems
[ ] Huntington's Disease
[ ] Hypertension
[ ] Insomnia
[ ] Kidney Disease
[ ] Liver Disease
[ ] Lung (Respiratory) Disease
[ ] Malnutrition
[ ] Measles
[ ] Meningitis
[ ] Multiple Sclerosis
[ ] Oxygen Deprivation
[ ] Parkinson's Disease
[ ] Pneumonia
[ ] Poisoning
[ ] Polio
[ ] Psychiatric Problems
[ ] Pulmonary Problems
[ ] Radiation Exposure or Therapy
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Senility (Dementia)
[ ] Stroke or TIA
[ ] Thyroid Disease
[ ] Tuberculosis
[ ] Venereal Disease
[ ] Whooping Cough
[ ] Other Disease/ Disability: _____

Details: _____

Have you been involved in any previous motor vehicle accidents? [ ] Yes [ ] No
If yes, please describe and provide dates: _____
_____
_____
Did you need to go to your doctor or the hospital? [ ] Yes [ ] No

Have you had any previous concussions or head injuries? [ ] Yes [ ] No
If yes, please describe and provide dates: _____
_____
_____
Did you need to go to your doctor or the hospital? [ ] Yes [ ] No

In the past, were you ever subjected to: physical abuse? [ ] Yes [ ] No
emotional abuse? [ ] Yes [ ] No
sexual abuse? [ ] Yes [ ] No
child neglect? [ ] Yes [ ] No
If yes, please indicate by whom and how long ago: _____
_____

Before this injury, have you ever been under the care of a psychiatrist, psychologist, or counsellor? [ ] Yes [ ] No
If yes, what were you seen for? _____
Name of doctor/ therapist: _____
How many sessions/appointments? _____

Are you currently receiving psychological therapy or counselling? [ ] Yes [ ] No
If yes, name of doctor/ therapist: _____
How many sessions have you completed? _____
Did you feel treatment is helpful? [ ] Yes [ ] No
If no, why? _____

Have you ever thought of suicide? [ ] Yes [ ] No
If yes, when was the last time you thought about it? _____
If yes, have you ever attempted suicide? [ ] Yes [ ] No

Have you had a psychological or neuropsychological evaluation before? [ ] Yes [ ] No
If yes, when and who was the evaluation completed with? _____

V) SUBSTANCE USE

Do you drink caffeinated beverages (coffee, tea, soft drinks, energy drinks, etc.)? [ ]Yes [ ]No
If yes, circle which drinks and indicate how much do you drink in a typical day? _____

Do you drink alcohol? [ ] Yes [ ] No
If yes, how many drinks do you have in a typical week? _____
Have you ever had a drinking problem? [ ] Yes [ ] No
If yes, please describe the problem(s) and date(s): _____

Do you use marijuana/cannabis currently? [ ] Yes [ ] No
If yes, which strain(s) and what method(s) do you use (e.g., THC, CBD, indica, sativa, hybrid, hashish, etc.; smoking, vaporizing, edibles, transdermal, etc.)? _____
_____
How much (e.g. in grams) do you use in a typical day? _____
How often do you use marijuana/cannabis? _____
Do you have a prescription for your cannabis use? [ ] Yes [ ] No
Have you ever had a problem with marijuana/cannabis? [ ] Yes [ ] No
If yes, please describe the problem(s) and date(s): _____

Do you use recreational drugs currently? [ ] Yes [ ] No
If yes, please indicate which drug(s): _____
Did you use recreational drugs in the past? [ ] Yes [ ] No
If yes, please indicate which drug(s): _____

Do you smoke cigarettes, vape nicotine, or chew tobacco (circle the ones applicable)?
[ ] Yes [ ] Never [ ] Quit when: _____
If yes, how many cigarettes do you smoke or how much do you use per day? _____

Have you ever been dependent on or abused prescription drug(s)? [ ] Yes [ ] No
If yes, please describe the drug(s) and date(s): _____

Have you participated in any treatment related to alcohol or drug use? [ ] Yes [ ] No
If yes, please describe and provide dates:_____

VI) PSYCHOSOCIAL HISTORY

Current marital status: [ ] Single [ ] Married [ ] Common Law
[ ] Separated [ ] Divorced [ ] Widowed
If married or common-law, how long have you been with your partner? _____
Spouse's name: _____ Spouse's occupation: _____

Do you have any children? [ ] Yes [ ] No
If yes, please list child(ren)'s name(s), age(s), and sex(es):

_____ _____
_____ _____

With whom are you now living and how long?_____

What are your hobbies or what did you like to do in your spare time *before you were injured*?
_____
_____

Are you still able to enjoy your hobbies or engage in the activities that you previously liked to do before you were injured? [ ] Yes [ ] No
If you no longer participate in many / all of your leisure interests, how come?
Cognitive issues (memory, attention, etc.) [ ] Yes [ ] No
Physical issues (pain, fatigue, etc.) [ ] Yes [ ] No
Psychological issues [ ] Yes [ ] No
Other: _____

Have you ever had a problem with gambling or other addictive behaviours? [ ] Yes [ ] No
If yes, please describe the problem(s) and date(s): _____

VII) CURRENT ISSUES

Briefly list any problems you may be having from a cognitive perspective (e.g., memory, concentration or other thinking skills): _____
_____

Briefly list any problems you may be having from a physical perspective (e.g.., physical injuries, limitations, pain, etc.): _____
_____

Briefly list any problems you may be having from an emotional perspective (e.g., depression, anxiety, anger or other emotional reactions:_____
_____

If you have any problems with activities of daily living (e.g., dressing, grooming, hygiene, toileting), please describe: _____

If you have any limitations in your ability to engage in household chores (e.g., laundry, yard work, cooking, home repairs, cleaning), please describe:_____

Are you currently driving? [ ] Yes [ ] No
If yes, do you limit your driving in any way?: _____
If not driving, please indicate why: _____
Did you take any time off from driving after you were injured? [ ] Yes [ ] No
If yes, for how long and why?: _____

In the past week, how many hours of sleep did you get each evening?_____
On average, how many hours of sleep do you usually get?_____
Do you find your sleep restful? [ ] Yes [ ] No
If no, why is your sleep disturbed_____
Do you nap during the day? [ ] Yes [ ] No
If yes, how many times and for how long? _____

Are you easily fatigued? [ ] Yes [ ] No
Is fatigue among your most disabling symptoms? [ ] Yes [ ] No
Does fatigue interfere with your work, family, or social life? [ ] Yes [ ] No

Please indicate any treatment you are currently involved in:_____
_____

Please indicate any treatment you have already completed related to your injury: _____
_____

If you have had prior treatment or are currently in treatment, are your symptoms improving, staying the same, or getting worse?_____

Have you engaged the services of a lawyer related to your injury? [ ] Yes [ ] No
If yes, name of lawyer: _____
If yes, is your lawyer aware you are here for this assessment? [ ] Yes [ ] No

Please sign and date below to indicate that you have completed this questionnaire to the best of your knowledge. Thank you for taking the time to complete this questionnaire.

_____
Client Signature

_____ _____ _____
Client name (please print) Date Pronoun (optional)