PACIFIC NEUROSCIENCE MEDICAL GROUP

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Neuropsychological Testing Appointment

When will it be?

Date:_____ Time:_____ Examiner: Choose

What will I have to do?

Each appointment will last approximately 3 hours (with breaks) and include:

1. **A Clinical Interview** *(approximately 30-45 minutes)*

   During this interview, you will be discussing your medical history and any cognitive or physical concerns that you may have. Please bring someone with you to this interview (e.g., caregiver, family member) as it is helpful to have someone else to provide additional information. This person is free to leave following the interview or they can sit in the waiting room while you complete the testing portion.

2. **Cognitive Testing** *(approximately 2-2.5 hours)*

   Testing will involve basic paper-and-pencil tasks, as well as motor tests, that are designed to assess skills in memory, language, attention and concentration, and higher-order executive abilities.

How will this benefit me?

The results of testing serve as an important diagnostic tool for physicians. For example, it may be used to:

- Aide in differential diagnosis
- Identify cognitive strengths and/or weaknesses
- Monitor disease progression
- Monitor potential medication side-effects
- Establish a baseline for continued monitoring of potential cognitive changes

What should I bring?

Be sure to complete and bring the attached questionnaire, any snacks or drinks you may want during the breaks, and a sweater or jacket.

Cancelled or Missed Testing Appointment Policy

Please call us at (805) 278-4148 as soon as possible if you are unable to attend your appointment. If it is necessary to cancel or reschedule your appointment, please call at least 48 hours in advance. Your early cancellation is needed to give us sufficient time to make this appointment available to someone else. If an appointment is not cancelled at least 48 hours in advance, you will be charged a $25 fee, which will not be covered by your insurance company. We require that this fee be paid prior to any future appointments. Thank you for your cooperation and understanding.

We look forward to working with you!

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NEUROPSYCHOLOGICAL QUESTIONNAIRE

IDENTIFYING INFORMATION:

Name: _____Date of Birth: _____Handedness: choose

Native language:_____ Cultural/ethnic background:_____

DEVELOPMENTAL HISTORY

1. Where were you born? _____
2. To the extent you are aware, please list any problems associated with your birth or the immediate time period after birth (e.g., oxygen deprivation): _____

   _____
3. Please check all that applied to your mother while she was pregnant with you:

   ☐ Drug or Alcohol use ☐ Cigarette smoking ☐ Psychological Problems
   ☐ Environmental toxin exposure ☐ Malnutrition ☐ Other:_____
   ☐ Illness ☐ Accidents _____
4. Please indicate any learning disabilities, developmental problems, etc.

   ☐ Delay in walking ☐ Dyslexia ☐ Other: _____
   ☐ Delay in talking ☐ ADHD _____

EDUCATIONAL HISTORY

1. What is the highest grade that you completed in school? _____
2. Please list any degrees received: _____
3. As a student, were your grades mostly ☐ A's ☐ B's ☐ C's ☐ D's or ☐ F's (check all that apply)?

WORK HISTORY:

1. Are you currently still working? ☐ Yes ☐ No. *If no:*
   a. What year did you retire? _____ Did your illness force you to stop working? ☐ Yes ☐ No
2. Please list current and prior jobs (starting with the most recent):
   b. _____
   (Company) (Title/Position) (Start year – end year)
   c. _____
   (Company) (Title/Position) (Start year – end year)
   d. _____
   (Company) (Title/Position) (Start year – end year)
   e. _____
   (Company) (Title/Position) (Start year – end year)
   f. _____
   (Company) (Title/Position) (Start year – end year)
4. Were you ever in the military? ☐ Yes ☐ No. *If yes,* please indicate:
   a. Length of service: _____Rank/branch: _____
   b. Position(s) held: _____

5. What community, volunteer, or other activities are you currently involved in?_____

_____

6. What are your current recreational interests (e.g., exercising, crossword puzzles)? _____

_____

CURRENT LIVING SITUATION

1. Please indicate your current marital status:

☐ Married: *Years married:*____ ☐ Divorced ☐ Widowed
Number of prior marriages: ____ ☐ Single ☐ Separated

2. Please specify the number of ____children, ____ grandchildren, and ____great-grandchildren you have, if applicable.
3. Is anyone your conservator or legal guardian? *If yes*, who? _____
4. What help or supervision do you need from others (check all that apply)?

☐ Completing finances ☐ Remembering to turn off the stove or water
☐ Remembering to take medications ☐ Dressing
☐ Operating appliances (e.g., oven) ☐ Showering
☐ Operating electronics (e.g., TV remote) ☐ Other: _____

4. Do you currently drive? ☐ Yes ☐ No. *If no*, when did you stop? _____ Please describe reason for stopping: _____

MEDICAL HISTORY

1. Please list any surgeries and year performed:

a. _____ Year: _____ d. _____ Year: _____
b. _____ Year: _____ e. _____ Year: _____
c. _____ Year: _____ f. _____ Year: _____

2. Please indicate current and past medical conditions or illnesses (check all that apply):

☐ High cholesterol ☐ Sleep apnea
☐ High blood pressure ☐ Seizure disorder (Specify type/frequency):
☐ Heart disease _____
☐ Diabetes (Type I ☐ or Type II ☐) ☐ Other(s): _____
☐ Thyroid problems (underactive _____

3. Have you ever experienced a stroke, head injury, or any other serious or neurological injury not mentioned above? ☐ Yes ☐ No. *If yes,* please describe:_____

_____

SUBSTANCE USE HISTORY

1. Do you have *any* history of alcohol use? ☐ Yes ☐ No. *If yes,* please specify:
   a. Age (or year) started _____ / Age (or year) stopped (if applicable) _____
   b. Type and amount consumed per day: _____

c. Please describe any history of heavy or frequent alcohol use? _____

_____

2. Do you have *any* history of smoking? ☐ Yes ☐ No. *If yes,* please specify:
   a. Age (or year) started _____ / Age (or year) stopped (if applicable) _____
   b. Type/amount consumed per day: _____
3. Do you have *any* history of illicit substance use (e.g., cocaine, marijuana, etc.)? ☐ Yes ☐ No
   If yes, specify type and frequency: _____

_____

PSYCHIATRIC HISTORY

1. Please indicate any history of mental health problems or diagnoses (check all that apply)?

   ☐ Depression ☐ Bipolar Disorder

   ☐ Anxiety ☐ Other(s): _____

2. Please describe any mental health treatment (psychotherapy, medication, etc.) received (current and past): _____

   _____

3. Have you ever experienced *any* hallucinations? ☐ Yes ☐ No. *If yes,* please:
   a. Describe them: _____

   _____

   b. Indicate when your first hallucination occurred? _____

COGNITIVE CHANGES

1. Please describe any cognitive problems you are having now:
   a. Difficulty with problem solving or reasoning (e.g., puzzles): _____

   _____

   b. Problems with speed of thinking: _____

   _____

   c. Problems with attention or concentration: _____

   _____

   d. Problems with memory: _____

   _____

   e. Problems with speaking or reading: _____

   _____

   f. Problems with spatial abilities (e.g., getting lost driving): _____

   _____

2. When did you first start noticing any of the above cognitive changes? _____
3. Please indicate progression of change: ☐ Gradual ☐ Rapid ☐ Sudden ☐ Stepwise

FAMILY HISTORY

1. Please indicate any family history of psychiatric, substance abuse, or neurological problems (check all that apply):

   ☐ Dementia (Type: _____)
   ☐ Parkinson's disease
   ☐ Strokes
   ☐ Diabetes
   ☐ Depression
   ☐ Alcohol abuse

2. Please list any other family history of medical conditions, neurodegenerative disorders, or psychological problems: _____

   _____

3. If applicable:

   a. At what age did your mother pass away? _____
   b. At what age did your father pass away? _____

PHYSICAL CHANGES

1. Have you experienced any of the following physical changes (check all that apply)?

   ☐ Tremor (Which hand? ☐ R, ☐ L, or ☐ Both)
   ☐ Balance problems
   ☐ Small handwriting
   ☐ Difficulty swallowing
   ☐ Increase in saliva
   ☐ Shuffling gait
   ☐ Freezing gait
   ☐ Magnetic gait (feeling like your feet are stuck to the ground by magnets)
   ☐ Decreased sense of smell
   ☐ Decreased muscle strength
   ☐ Decreased coordination
   ☐ Softened speech
   ☐ Slurring and/or stuttering
   ☐ Visual complications
   ☐ Other(s):_____
   _____
   _____

   If yes to any of the above items:

   a. Which symptom occurred first, and when did it start? _____
   b. Are you taking medication(s) for your symptom(s) (e.g., levodopa)? ☐ Yes ☐ No. *If yes:*
      i. Describe any improvement in your symptom(s) since beginning the medication(s):
      _____
      _____

2. Have you ever been diagnosed with Parkinson's disease? ☐ Yes ☐ No. *If yes:*

   a. When were you diagnosed? _____

3. Please describe any other current concerns or difficulties not mentioned above: _____

   _____

   _____

   _____

This section is to be filled out by a caregiver, friend, or family member.

Name: _____ Relationship to patient:_____

1. Does the patient demonstrate:
   a. Difficulty with problem solving or reasoning (e.g., puzzles)? If so, please describe: _____
   _____
   _____
   b. Problems with speed of thinking? If so, please describe: _____
   _____
   _____
   c. Problems with attention or concentration? If so, please describe:_____
   _____
   _____
   d. Problems with memory? If so, please describe: _____
   _____
   _____
   e. Problems with speaking or reading? If so, please describe: _____
   _____
   _____
   f. Problems with spatial abilities (e.g., getting lost)? If so, please describe: _____
   _____
   _____
2. When did you first notice any of the above cognitive changes? _____
3. Please indicate progression of change: ☐ Gradual ☐ Rapid ☐ Sudden ☐ Stepwise
4. Has the patient ever harbored any thoughts or beliefs that you consider unusual (e.g., believing others are stealing from them or trying to break into their home)? ☐ Yes ☐ No. *If yes*, please describe: _____
   _____
5. Has the patient ever exhibited any hallucinations, personality changes, or other unusual behaviors not previously mentioned? If yes, please describe: _____
   _____
   _____
6. Does the patient demonstrate any difficulty:

   ☐ Completing his/her finances
   ☐ Remembering to take medications
   ☐ Operating appliances (e.g., oven)
   ☐ Operating electronics (e.g., TV remote)
   ☐ Remembering to turn off the stove or water
   ☐ Cooking
   ☐ Cleaning
   ☐ Other: _____

6. Please describe any other concerns or difficulties demonstrated by the patient: _____
   _____
   _____