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## DATA QUESTIONARE SHEET

**Today's Date:** _____

**Name:** _____ **Date of Birth:** _____ **Age:**_____ **Referred by:**_____

**Major Complaint/Problem:** **(Reason You are seeing the Psychologist/Doctor):**_____

_____

_____

_____

**Date of your complaint/impairment/injury onset?** **(Estimated Date)** _____

**Developmental History** **(Specify on line provided):**

**Birth Place:**_____ **Place Raised:**_____

Number of Siblings:_____ Your Order (First, Middle, etc.):_____

**Mother's Age at Birth:**_____ Mother's Occupation During your Childhood:_____

Relationship with Mother through Childhood:_____

**Father's Age at Birth:**_____ Father's Occupation During your Childhood:_____

Relationship with Father through Childhood:_____

**List if Other Raised you:** **(Stepfather, Grandma, etc.)**_____

From what age did they raise you?_____ To what age did they raise you if not 18?_____

Their Occupation During your Childhood:_____

Relationship them through Childhood:_____

**Developmental History** **Continued (Check all that apply, specify on line provided):**

**Birth Complications**

- ☐ Low Birth Weight
- ☐ Deformity (specify)_____
- ☐ Oxygen Deprivation
- ☐ Illness (specify)_____
- ☐ Premature
- ☐ Birth Trauma

**Developmental Milestones** **(Check, if any, event(s) were delayed/impaired during infancy/toddler stages):**

- ☐ Standing
- ☐ Talking
- ☐ Bedwetting
- ☐ Walking
- ☐ Potty Training

**Childhood Diseases/Surgeries:**

- ☐ Loss of Consciousness
- ☐ Seizure
- ☐ Concussion
- ☐ Oxygen Deprivation
- ☐ Tonsillectomy
- ☐ Near Drowning
- ☐ Convulsions
- ☐ Accidental Poisoning
- ☐ Encephalitis
- ☐ Meningitis
- ☐ Appendectomy
- ☐ High Fever (over 104F)
- ☐ Cerebral Palsy
- ☐ Pneumonia
- ☐ Multiple Sclerosis
- ☐ Allergies_____
- ☐ Cut Requiring Stitches
- ☐ Asthma/Bronchitis
- ☐ Broken Bones_____
- ☐ Cancer
- ☐ Other _____

**Educational History**

**Special Education Classes/Learning Disabilities**

- ☐ Yes, List_____
- ☐ No

**Schools Attended** (List Schools Attended from High School through College/Professional School by Age):

| Name of School | Located in City, State | Attended From what Age to What Age? (ex. 14-18) | Dates Attended | Degree/Special Awards Earned | GPA |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |

**Occupational History** (List Summary of Job/Career History from past to present):

| Company | Job Title | Approximate Dates From Date to End Date | Tasks of Job | Problems with Job? If Yes, list specific problems. |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| | | | | |

**Disability Status** (Have you been determined Disabled?)

☐ Yes, Specify:_____ ☐ No

**Military Service**

| **Branch** | **When ?** | **Length of Service** | **Where?** | **Rank** | **Service related injuries, disorders, limitations, exposures, etc.** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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**Legal History**

(Check the box(s) of all legal matters you have been involved in from school age to present, then explain checked items in the table that follows)

☐ Truancy
☐ School Suspension
☐ Court matters
☐ Misdemeanor Charges
☐ Felony Charges
☐ Jail/Prison Time
☐ Probation/Parole
☐ Victim of a Crime
☐ Victim of Violence
☐ Lawsuit
☐ DUI
☐ Assaults
☐ Drug Possession Charges
☐ Public Intox
☐ Other Legal Charges
☐ Accused of Abuse
☐ Victim of Abuse
☐ Parental Rights Taken by DHS/other legal entity
☐ Other:_____

**Legal History Detail**

| What: | Explanation/Further Details: | When (Estimated Date): | Where (What State/Specific Legal Entity): | Result/Consequences: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Substance Use**

| What Substance? Tobacco? Alcohol? Marijuana? Prescription Pills? Cocaine? Meth? Etc. List All. | Used From What Age to What Age? | How often and How much each time? | Any Legal or other Consequences from using? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Current History

*Place an ( X ) in front of items you have or have had problems with:*

____ Acid reflux (heartburn)
____ Alcoholism / other addiction
____ Allergies (environmental)
____ Anxiety
____ Asthma
____ Arthritis
____ Cancer (specify type _____)
____ Coagulation (bleeding or clotting) problem
____ Cholesterol problem
____ Chronic low back pain
____ Dementia
____ Depression
____ Diabetes mellitus
____ Erectile dysfunction
____ Gastric (GI) Issues
____ Head Injury
____ Heart disease (specify type_____)
____ Hypertension (high blood pressure)
____ Irritable bowel syndrome
____ Irregular Heart beat/rhythm
____ Migraines
____ Musculoskeletal Problems
____ Osteopenia or Osteoporosis
____ Prostate problem
____ Pulmonary Issues (Lung/Breathing)
____ Stroke
____ Thyroid problem
____ Urinary Issues
____ Brain Injury
____ Other problems (list below):

_____
_____
_____

## Review of Symptoms

*Place an ( X ) in front of items you have:*

Vision:
_____ Glasses/Contacts
_____ Blurred or Double Vision
_____ Loss of Vision/Blind Spots

Hearing:
_____ Hearing Aid (left, right, or both ears)
_____ Loss of Hearing
_____ Ringing
_____ Tone Deafness
_____ Ear infections (tubes placed)

Motor: (specify where on line)
_____ Decreased Coordination
_____ Weakness
_____ Paralysis
_____ Spasms/Tremors
_____ Chewing/Swallowing
_____ Range of Movement/Flexibility

Pain: (specify where on line)
_____ Chronic Pain (Long term)
_____ Acute Pain (Short term, due to injury, sprain, etc)

Tactile: (specify where on line)
_____Numbness/Loss of Sensation
_____Tingling/Burning
_____Pain/Temperature Sensitivity

Taste & Smell:
_____Change in Taste
_____Bad Tastes
_____Change in Smell
_____Bad Smells

Consciousness:
_____Seizures or Fits
_____Fainting or Blackout Spells
_____Lapses of Time
_____Dizziness While Sitting
_____Dizziness Upon Standing
_____Staring Episodes

## Review of Cognitive Symptoms

*Place an ( X ) in front of items you have:*

Attention:

_____ Distractibility
_____ Confusion/Orientation Deficits (forgetting day, date, or whereabouts)
_____ Concentration Deficits (Must repeatedly read a book or newspaper before it makes sense. Cannot follow television show from start to finish)
_____ Path Finding Problems (Patient gets lost going to familiar places and/or has problems taking a bus)

Memory:

_____ Immediate Memory (names, faces, telephone numbers)
_____ Visual Memory Problems
_____ Verbal Memory Problems
_____ Memory Change (example) _____
_____ Short-term Recall - Difficulty remembering newly learned experience.
_____ Long-term or Remote Recall - Difficulty remembering past experiences/events
_____ Absent-Mindedness
_____ Memory for Names/Faces
_____ Memory for Numbers
_____ Old Learning (e.g., taking a bus, cooking a meal/dish, simple math/spelling)
_____ New Learning (able to learn something new involving 3 or 4 steps)

Speech:

_____ Difficulty Expressing Thoughts
_____ Difficulty Understanding Others
_____ Change in Articulation/Slurred or Mumbled Speech
_____ Trouble Finding Correct Word or Desired Word
_____ Saying Wrong or Inappropriate Word
_____ Word-naming Problems
_____ Hesitations
_____ Substitutions
_____ Speech Impediments
_____ Difficulty Constructing Sentences

Thought Processes:

_____ Trouble Organizing Thoughts
_____ Trouble Organizing Actions
_____ Slowed Thinking
_____ Decreased Problem Solving Ability
_____ Changes in Ability to Read
_____ Changes in Ability to Write
_____ Changes in Ability to Spell
_____ Changes in Ability to do Math

Other Symptoms:

_____ Unexplained or Increased Crying Capacity
_____ Sadness
_____ Hyperactivity
_____ Temper Outbursts
_____ Irritability/Argumentativeness
_____ Impulsiveness
_____ Change in Motivation
_____ Loss of Pleasure
_____ Anxiety/Tension/Nervousness
_____ Fears
_____ Social Withdrawal/Isolation
_____ Change in Alcohol or Tobacco Use
_____ Racing Thoughts
_____ Worry
_____ Sleep Change (specify) _____
_____ Number of Hours per Night_____
_____ Stress-related Sleep Difficulties
_____ Weight Loss/Gain
_____ Appetite Change
_____ Intentional Weight Loss
_____ Libido Changes
_____ Mood Swings
_____ Agitation/Panic Attacks
_____ Hallucinations
_____ Delusions
_____ Suicide Attempts/Gestures/Ideation
_____ Suicidal Thoughts/Ideation

## Activities of Daily Living

Describe your current functioning level in each area by placing a number( 0-3) on the first line labeled *Number*. Then list any problems, difficulties, or factors that may cause difficulties in this area on the line beside it.

***Number:***

0= I can't do or participate in this task at all.
1= I can marginally do or participate in this task.
2= I can reasonably do or participate in this task.
3= I do or participate in this task very well.

***Examples of*** **Problems/Factors Affecting Functioning*:***

| | | |
|---|---|---|
| Stamina | Strength | Self Discipline |
| Memory | Mental | Commitment |
| Anxiety | Depression | Concentration |
| Stress | Physical Limitations | Other-Please specify |

| | Number | Problems/Factors Affecting Functioning |
|---|---|---|
| **Cooking & Meal Preparation:** | _____ | _____ |
| **Laundry and clothing care:** | _____ | _____ |
| **Grocery Shopping:** | _____ | _____ |
| **Organization, Tidiness and Routine Cleaning:** | _____ | _____ |
| **Ability to Manage, Budget and Save Money:** | _____ | _____ |
| **Compliance to Healthy Diet Everyday:** | _____ | _____ |
| **Daily Exercise of at least 30 minutes:** | _____ | _____ |
| **Bathing, Coordinating Outfits, Grooming:** | _____ | _____ |
| **Social Activities and Functions Involvement:** | _____ | _____ |
| **Recreational Hobbies & Activities:** | _____ | _____ |

## Current History

**Handedness(circle one):** Right Left Ambidextrous. **Highest Education Level Completed**_____

**Current Occupation**:_____**Current work hours per week**:_____

**Ethnicity**:_____ **Religious or Other Group Affiliation**:_____

**Marital Status** (Circle one): Single Married Divorced Remarried Separated Widowed

**Number of Children**:_____**List Children's ages**:_____

**Current Living Arrangements** (Circle one): Live Alone Live w/ Roomate Live w/ Spouse Live w/ Parents Nursing Home

Other:_____

**List Recreational Activities**:_____

**List Group(s) or Organization(s) involved in**:_____

ADDITIONAL INFORMATION YOU WOULD LIKE TO COMMUNICATE TO DOCTOR:

_____

_____

_____

_____

_____

_____