Howard Mangel, Ed.D.
Somerset Neuropsychological Services
Licensed Psychologist
NJ License 35SI00256900

MAIL: PO Box 805 Belle Mead, NJ 08502
OFFICE: 17 West Cliff St., Somerville, NJ 08876
VOICE: 908 369 0557

History Questionnaire

Instructions: Please fill out this form to help the psychologist learn useful information about you that would assist the evaluation or treatment process. **Please provide all the information requested**. Be assured that all information given on this form, as well as in treatment, is considered confidential and treated with respect and in a manner consistent with the privacy rules of the Health Insurance Portability and Accessibility Act (HIPAA). Please return this at the first visit if it was sent to you in advance.

PERSONAL INFORMATION

Name (full): ____

Home address: ____

____

Phone number (with area code): Home: ____________________ Work: ____________________

Cell ____________________ E mail address: ________________________OK to use? Y or N

Age: __________ Date of birth: ____________ Sex: Male__ Female__ Handedness: Right ___ Left ___

Marital Status (check one) __Single __Married __Divorced __Separated __Other ( )

REFERRAL INFORMATION:

By whom were you referred? ____

PLEASE DESCRIBE, IN YOUR OWN WORDS, THE REASON(S) YOU ARE HERE:

____

____

Please describe your current overall health: ____

____

Name(s) of primary AND other treating doctors:

Primary Physician: ____________________ **Neurologist**: ____________________

His/her address(es): ____________________ His/her address: ____________________

Office phone number(s): ____________________ Phone Number: ____________________

Rehab Medicine dr: ____________________ **Psychiatrist**: ____________________

His/her address(es): ____________________ His/her address: ____________________

Office phone number(s): ____________________ Phone Number: ____________________

Other dr: (specialty:)____________________ **Other dr: (specialty:)** ____________________

His/her address(es): ____________________ His/her address: ____________________

Office phone number(s): ____________________ Phone Number: ____________________

In the past year, have you had any significant medical or physical problem that is affecting you now?

YES___ NO___ Please describe: ____

Have you ever had: **If so, list date(s):**

Head injury/traumatic brain injury Yes___ No___ _______________

Stroke/CVA/Aneurysm Yes___ No___ _______________

Other brain injury/illness? Yes___ No___ _______________ (if so, what condition?)

Seizures/epilepsy Yes___ No___ _______________

Heart attack Yes___ No___ _______________

Diabetes Yes___ No___ _______________

Surgery Yes___ No___ _______________

Other major illness or medical condition Yes___ No___ _______________

Please explain any that you checked yes to: ____

____

Were you ever unconscious or in a coma? ___Yes ___ No If so, when & for how long? ______________________

____

Have you had or do you now have: (CHECK AS APPROPRIATE)

Learning disabilities? Yes___ No___ Alcohol or drug treatment? Yes___ No___

Psychiatric/psychological treatment? Yes___ No ___ Individual or family therapy? Yes___ No___

If yes, please explain: ____

MEDICATIONS & *HERBAL SUPPLEMENTS*

Please list what medications, if any, that you are currently taking:

Name of medicine:	*Prescribing MD:*	*Dosage:*	*What is it taken for?*

MEDICAL OR PSYCHOLOGICAL TESTING

PSYCHOLOGICAL: Have you ever had psychological testing before? ___Yes ___No

Have you had *Neuropsychological* testing before? ___Yes ___No

If yes, please give details (where, when, results): ____

____

MEDICAL TESTS:

Have you ever had an MRI or CT scan of the head? Yes ___ No ___ If so, when? ____________________________

What were the results? ____

Have you had an EEG (brain wave scan)? Yes ___ No___

If so, when and what results were found? ____________________________ __________________________________

Any other significant medical testing? Yes ___ No___ If yes, of what and what were the results?

____

ALCOHOL AND DRUG USE

How often do you drink alcoholic beverages? (*Circle answer below*)

Rarely or never	1-2 times a month	3-4 times a month
Every week	Several times a week	Every day or almost every day

Do you think you have a drinking problem? ___Yes ___No

Have you ever been treated for alcoholism? ___Yes ___No

12 Step groups like AA: Have you attended? ___Yes ___No Now or in past (circle one)

Other 12-Step groups? *If so, which one(s):* ________________

Do you use any recreational drugs or prescription medications that are not prescribed to you?

___Yes ___No *If yes, how often:* Rarely or never 1-2 times a month

3 times a month Once a week Several times a week Every day or almost every day

Please circle any of the following recreational drugs that you use or have used in the past:

Marijuana	Cocaine	LSD	Amphetamines
Heroin	Quaaludes	Crack cocaine	Other _______________

Smoking: Do you now smoke cigarettes? ___Yes ___No

How often/how many a day? _______________________ Since when? _____________

If you smoked in the past, when did you quit? _________

FAMILY HISTORY

What is your mother's name? ________________________ Is she still living?_________

If deceased, when? _____________ Cause? ______________________________

What is your father's name? _________________________ Is he still living? _________

If deceased, when? _____________ Cause? ______________________________

Brothers or sisters? Please list names and ages: ____

Spouse's name & age __________________________ How long married/together? _____________

Do you have any children?________ If so, please list their names and ages: ________________________________

____

With whom do you live now? ____

If divorced, separated or widowed, how long? ____________________ Married how long prior to change? ___________

Is there a *family* history of: (check any that apply *and write details here:*)

__Mental retardation __Neurologic problems (stroke, etc.)

__Learning disabilities __Psychiatric/psychological problems

SCHOOL & WORK HISTORY

Education

What is the highest grade or academic level you completed? (check one):

_____ Some high school (last grade finished: ; what year did you leave school?)

_____ High school graduate (year?)

_____ Vocational-tech or trade school (what trade/skills?)

_____ Some college (estimated # of credits obtained:)

_____ College degree: ___Associate's ___Bachelor's *what was your major?* _________________

_____ Post college: ___Some grad school _____Master's ____Post Master's

(details of post college academic work:)

Did you like school? ______ What was your average grade in school? _________

Do you hope to resume or continue your education? _______________________

In what area(s)? ____

Work

Are you working now? ___Yes ___No

What is your current *or most recent* occupation? ____

How long at this job? _____ Reason for leaving? __________________________________

Name, address of your employer ____

Do you/did you enjoy your work? ___Yes ___No What did you like about it? ____________________

What other jobs have you had in the past? ____

If you aren't working now, do you want to return to work? __________________________

Do you think that you will have any difficulties returning to work (if you are NOT working now)? If so, what are they?

____

What is/was your typical annual income, approximately? ____

Leisure activities

How do you spend your leisure time? ____

What hobbies or interests do you have? ____

Have you had to stop doing or change how you're doing any of these activities since your illness/accident?

____

What else would be useful for us to know about to help you?

____

____

THANKS FOR COMPLETING THIS QUESTIONNAIRE.