Meyers Neuropsychological Questionnaire

Delta Family Clinic South

Patient Name: _____

Age: _____ **Date of Birth**: _____ **Gender:** _____

1. Education:

High School	Yes OR No	
GED	Yes OR No	if yes, last year of high school completed: _____
Special Education	Yes OR No	
College	Yes OR No	how many years completed: _____
		Degree earned (if applicable): _____

2. Where did you attend school?

High school: _____ State: _____

College:_____ State:_____

3. Handedness: right OR left

4. Marital Status: Single Married Divorced Widowed

Are you currently employed? Yes OR No

If **no**, and you attend school please, check student. If neither, please skip to question # 6.

If **yes** please complete the following.

5. Occupation: _____

Please then choose the highest occupational level listed below.

☐ Unskilled:

Jobs that require no training, certification or license. Any training required for this type of occupation occurs on the job. This includes most labor and manufacturing jobs.

☐Semi-skilled:

Occupations that require training or certification, but the training or Certification period lasts 30 days or less are classified as semi-skilled. Some common examples of semi-skilled occupations include semi-truck driver (requires a CDL) or a Certified Nurses Assistant (which requires 1-3 weeks of training. In addition, individuals who run their own farm are also considered semi-skilled.

☐ Skilled:

Occupations that require certification or training lasting longer than 30 days are classified as skilled occupations. The training can be on-the-job or in the classroom. Examples include electrician, welder, and contractor.

☐ Managerial/Office/Sales:

This classification of occupation does not necessarily require training or certification, but is not considered a laborer type position. For instance, persons in retail sales, secretarial staff, and office management fall into this classification.

☐ Technical/Professional:

These occupations require an advanced degree, such as pharmacist, doctor, psychologist, social worker, or teacher.

☐ Student: Persons who are currently enrolled in an educational institution (whether elementary, secondary, or university) are classified as students.

Tell me about your work history from high school on.

_____
_____
_____

6. Are you currently collecting disability benefits from the government? Yes OR No

7. Independence: Please choose an option below

☐ Yes:
Persons who are living on their own or with others and assume the responsibilities of self-sufficiency are classified as independent. In addition, children, who are living at home with their parents, are also classified as independent because they are as independent as society would expect them to be.

☐ Partially Independent and Driving:
Once a person has lost the ability to supply one of their own basic needs (i.e. care for own finances or cooking meals, managing medications) then they are partially independent; but the individual is still allowed to drive.

☐ Partially Independent and Not Driving:
Once a person has lost the ability to supply one of their own basic needs (i.e. care for own finances or cooking meals, managing medications) then they are partially independent; and the individual is also not allowed to drive.

☐ Not Independent:
Has lost independence in two or more areas of function and is not allowed to drive

8. Who referred you to Delta Family Clinic? _____

Referral info**:** _____
_____

9. What was the reason for the referral: (Head injury, Memory Loss, Car Accident Etc.)

_____
_____
_____

10. What was the date of this incident? _____ OR N/A

11. Tell me about how your accident or illness occurred:

_____
_____
_____

12. Please list any hospitalizations or medical treatment you sought for your current difficulties including medical studies, brain scans, etc.

_____
_____
_____

13. Did your accident or illness cause you to lose consciousness or alter your consciousness?
Yes OR No

14. List any symptoms you have been experiencing secondary to your current difficulties.

_____

_____

15. Please list all emotional symptoms:

_____

_____

16. Please list all physical symptoms:

_____

_____

17. Please list all thinking symptoms:

_____

_____

Historical Data

18. Tell me about your parents. If they're deceased, tell me how.

_____

_____

_____

19. What was your family life like when you were growing up?

_____

_____

_____

20. Tell me about your siblings. How many? Still living?

_____

_____

_____

21. Tell me about your history of relationships including marriage(s):

_____

_____

_____

22. Tell me about your children. Age, gender, relationship.

_____

_____

_____

Current Life Data

23. What is causing the most stress in your life?

_____

24. What do you like to do socially in your leisure time?

_____

25. Do you currently possess a valid driver's license? If no, why?

_____

26. Tell me about your family's medical history.

_____

_____

27. Do you have, or have you ever had, a history of mental health involvement (therapy or hospitalizations)?

_____

_____

28. How often do you consume alcoholic beverages? (circle one)

Frequent Occasional Infrequent Never Prior Dependency

29. What is your current or past history of recreational drug use/abuse?

_____

_____

_____

30. Has there been any change in your eating or sleeping since your current difficulties began?

_____

31. What have your emotional reactions been to your current difficulties?

_____

32. With regard to mental abilities, how has your memory, attention span, concentration, etc. been?

_____

_____ _____

Patient/ Guardian signature Date

_____ _____

Therapist Signature Date