

**Meyers Neuropsychological Questionnaire**  
Delta Family Clinic South

**Patient Name:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

**1. Education:**

High School	<u>Yes</u> OR <u>No</u>	if yes, last year of high school completed: _____
GED	<u>Yes</u> OR <u>No</u>	
Special Education	<u>Yes</u> OR <u>No</u>	
College	<u>Yes</u> OR <u>No</u>	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 onset of illness? \_\_\_\_\_ OR N/A

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

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

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

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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

17. Please list all thinking symptoms: \_\_\_\_\_  
\_\_\_\_\_

**Family and Relationship Data**

18. What was your family life like when you were growing up? \_\_\_\_\_  
\_\_\_\_\_

19. Tell me about your history of relationships including marriage(s): \_\_\_\_\_  
\_\_\_\_\_

**Current Life Data**

20. What is causing the most stress in your life? \_\_\_\_\_  
\_\_\_\_\_

21. Do you currently possess a valid driver's license? If no, why: \_\_\_\_\_  
\_\_\_\_\_

22. Tell me about your family's medical history: \_\_\_\_\_  
\_\_\_\_\_

23. Do you have, or have you ever had, a history of mental health involvement (therapy or hospitalizations): \_\_\_\_\_  
\_\_\_\_\_

24. Has there been any change in your eating or sleeping since your current difficulties began: \_\_\_\_\_  
\_\_\_\_\_

25. What have your emotional reactions been to your current difficulties: \_\_\_\_\_  
\_\_\_\_\_

26. Regarding, mental abilities, how has your memory, attention span, concentration, etc. been: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient/ Guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date