SYMPTOMS:

- What was the initial symptom or symptoms? Please describe:

  CHECK ONE:
  - ☐ Memory and thinking problems first?
  - ☐ Or motor changes?
  - ☐ Or changes in behavior?
- When were these initial symptoms first observed?

  CHECK ONE:
  - ☐ >2 years ago
  - ☐ 1-2 years ago
  - ☐ 6 months - 1 year ago
  - ☐ 3 months - 6 months ago
  - ☐ Within the last 3 months
- Did the symptoms occur suddenly or develop gradually over time?
  - ☐ Suddenly
  - ☐ Gradually
- Have the symptoms changed over time?

  CHECK ONE:
  - ☐ Stable
  - ☐ Stable, then sudden decline
  - ☐ Steadily worsened
  - ☐ Fluctuating
  - ☐ Improved
- Has the patient ever suffered symptoms of delirium? (periods of extreme confusion or disorientation due to illness, medication side-effects or being in the hospital)
  - ☐ Yes

    If Yes, please describe the event or events ***separately***
  - ☐ No

COGNITIVE

Does the patient have problems with:

- ☐ Recalling recent events
- ☐ Recalling details of conversations
- ☐ Repeating questions or stories
- ☐ Misplacing or losing items
- ☐ Forgetting dates, schedules or appointments
- ☐ Recognizing familiar places, people or objects
- ☐ Recalling events from the distant past
- ☐ Learning a new route to a familiar place
- ☐ Becoming lost or confused in familiar places
- ☐ Finding words or expressing thoughts
- ☐ Understanding other people
- ☐ Carrying out multi-step activities
- ☐ Multitasking
- ☐ Focusing, concentrating, or being easily distracted

DAILY TASKS - Does the patient have problems with…

- Medications
  - ☐ Procuring, ensuring refills made on time
  - ☐ Preparing/organizing medications
  - ☐ Recalling use and/or dosage
  - ☐ Forgetting to take medications
  - ☐ Making other medication errors

- Finances
  - ☐ Preparing/completing taxes
  - ☐ Organizing/preparing bill payment
  - ☐ Bill payment (paying late or twice)
  - ☐ Managing checkbook/online account
  - ☐ Calculating a tip
  - ☐ Making change

- Household Tasks
  - ☐ Shopping or making purchases
  - ☐ Cooking, grilling, or preparing food
  - ☐ Household chores or simple repairs
  - ☐ Doing laundry
  - ☐ Arranging transportation
  - ☐ Using technology (tools, microwave, thermostat, computer, smartphone)
  - ☐ Shaving
  - ☐ Combing/styling hair
  - ☐ Brushing teeth
  - ☐ Applying or removing makeup
  - ☐ Bathing or showering
  - ☐ Dressing or undressing
  - ☐ Eating using utensils
  - ☐ Chewing and swallowing correctly/safely
  - ☐ Using the toilet

DAILY LIFE

Compared to baseline, any reduced interest, function or participation in:

- ☐ --Working, Job, Volunteering
- ☐ --Caring for and about family members
- ☐ --Socializing
- ☐ ---Keeping up friendships
- ☐ ---Maybe making new
  - o friends
- ☐ --Community pursuits (Church, Clubs, Meetings)
- ☐ --Hobbies and Interests
- ☐ --Keeping one's Mind, Emotions, Body and Spirit in balance to maintain wellness and well-being
- ☐ Healthy lifestyle habits neglected (sleep, diet, physical activity/exercise, cognitive stimulation)

JUDGEMENT AND SAFETY -

- Does the patient have problems with:
  - ☐ Leaving the stove on or microwave fires
  - ☐ Leaving the water on
  - ☐ Having trouble regulating the thermostat
  - ☐ Having access to weapons or power tools
  - ☐ Wandering off or getting lost
  - ☐ Forgetting to eat
  - ☐ Living alone or being left alone
  - ☐ Being susceptible to solicitors

- Have there been recent falls or significant stumbles?
  - ○ Yes
  - ○ No

- Does the person currently drive a motor vehicle?
  - ☐ Yes
  - ☐ No
- If he/she drives, `are you concerned about his/her safety?
  - ☐ Yes
  - ☐ No
  - If Yes, are there any specific concerns you have about their driving:
    - ☐ Drives too fast
    - ☐ Drives too slow
    - ☐ Gets lost
    - ☐ Recent accidents/citations
    - ☐ Gets angry or flustered
    - ☐ Turns in front of other cars
    - ☐ Hits/scrapes objects
    - ☐ Trouble parking
    - ☐ Straddles lanes
    - ☐ Runs overs curbs
    - ☐ Doesn't pay attention
    - ☐ OTHER:

MOOD & BEHAVIOR: Please answer the following questions based on changes that have occurred since the patient first began to experience memory problems. Check the box only if the symptom has been present in the last month.

- ☐ Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?
- ☐ Does the patient experience or show hallucinations, such as false visions or voices? Does he/she seem to hear or see things that are not present?
- ☐ Is the patient resistive to help from others at times or hard to handle?
- ☐ Does the patient seem sad, or say that he/she is depressed?
- ☐ Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax or feeling excessively tense?
- ☐ Does the patient appear to feel too good or act excessively happy?
- ☐ Does the patient seem less interested in his/her usual activities, or in the activities or plans of others?
- ☐ Does the patient seem to act impulsively, for example, talking to strangers as if he/she knows them or saying things that may hurt people's feelings?
- ☐ Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?

- ☐ Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string or doing other things repeatedly?
- ☐ Does the patient awaken you during the night, rise too early in the morning or take excessive naps during the day?
- ☐ Has the patient lost or gained weight, or had a change in the type of food he/she likes?

PERSONALITY & BEHAVIOR

- Please describe the patient's life-long personality Check all that apply:
  - ☐ Even tempered
  - ☐ Quick tempered
  - ☐ Optimistic
  - ☐ Pessimistic
  - ☐ Socially outgoing
  - ☐ Homebody
  - ☐ Worrier
  - ☐ Low self-esteem
  - ☐ Assertive
  - ☐ Manipulative
  - ☐ Hypochondriac
  - ☐ Generous/caring
  - ☐ Good sense of humor
  - ☐ Stubborn
  - ☐ Complainer
- Has the patient experienced any CHANGES in personality or behavior? Check all that apply:
  - ☐ Increased impulsivity
  - ☐ Agitation
  - ☐ Loss of empathy
  - ☐ Risky behaviors
  - ☐ Reduced frustration tolerance
  - ☐ Difficulty getting started
  - ☐ Socially inappropriate behavior
  - ☐ Social withdrawal
  - ☐ Increased irritability
  - ☐ Reduced motivation
  - ☐ Restlessness
  - ☐ Other, describe: _____

SLEEP –

Does the patient have problems with any of the following

- ☐ Acting out dreams" while sleeping (punching or flailing arms in the air, shouting or screaming)
- ☐ Legs repeatedly jerking or twitching during sleep (not just when falling asleep)
- ☐ A restless, nervous, tingly, or creepy-crawly feeling in the legs that disrupts falling/staying asleep
- ☐ Walking around the bedroom or house while asleep
- ☐ Snorting or choking themself awake
- ☐ Seem to stop breathing during sleep
- ☐ Increased need for sleep
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Taking over-the-counter sleep aids and/or THC/CBD gummies to sleep?

MEDICAL HISTORY - additional questions

- Has the patient had imaging, a scan of the brain?
  - ☐ Yes
    - If Yes, where? _____
  - ☐ No
- Has the patient had neuropsychological testing?
  - ☐ Yes
    - If Yes, where? _____
  - ☐ No

- Has the patient had any recent hospitalizations?
  - ☐ Yes
  - ☐ No
    - If Yes, please give details (which hospital, where) ***separately***

Social History - additional questions

- Highest level of formal education completed:
  - ☐ Less than high school
  - ☐ GED
  - ☐ High school
  - ☐ Some college
  - ☐ Associate degree
  - ☐ Bachelor's degree
  - ☐ Master's degree
  - ☐ Doctoral degree
- If retired, did the patient retire due to problems with their memory or thinking?
  - ☐ Yes.
    - If so, at what age? _____
  - ☐ No
- If working, what is the patient's current occupation?

  - ☐ _____
  - ☐ How many years in that occupation?

- If not working, what was the patient's most recent occupation?

  - ○ _____
  - ○ How many years in that occupation?
- List any hobbies and interests that the patient has/had

  - ○ _____
  - ○ Does/did memory and thinking problems affected) working or hobbies?
  - ○
- Number of living children:

  _____

- Current living situation:
  - ☐ Alone in home/apartment
  - ☐ With spouse/significant other
  - ☐ With other family or friends
  - ☐ Assisted living
  - ☐ Nursing home
  - ☐ Other:

- Does the patient currently smoke or have a history of smoking?
  - ☐ Yes
    - How many years of smoking? _____
    - How many packs per day? _____
  - ☐ No
    - Never smoked
    - Quit in year: _____

- Does the patient currently drink alcohol or have a history of drinking alcohol?
  - ☐ Yes
    - How many drinks per week? _____
    - Any history of excessive use (now or in the past)? _____

      _____
  - ☐ No
- Has the patient used medical marijuana, recreational drugs, and/or misused prescription medications?
  - ☐ Yes
    - Type:
    - Duration
  - ☐ No

Family History - additional questions

- Does the patient have a blood relative with any of the following?
  - Dementia/Senility/Alzheimer's
    - Age at onset (circle all that apply)
      - <55
      - 55-64
      - 65-74
      - >75
  - Parkinson's disease
    - Age at onset (circle all that apply)
      - <55
      - 55-64
      - 65-74
      - >75
  - Stroke
    - Age at onset (circle all that apply)
      - <55
      - 55-64
      - 65-74
      - >75

- Psychiatric/Mental Illness
- Intellectual disability