Visit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person Completing Form:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer the following questions based on changes that have occurred since the patient first began to experience memory problems.

**Circle “YES” only if the symptom(s) has been present in the last month. Otherwise, circle “NO.”**

**For each item marked “YES”:**

1. **Rate the SEVERITY of the symptom (how it affects the patient):**

**1 = Mild**  (noticeable, but not a significant change)

**2 = Moderate** (significant, but not a dramatic change)

**3 = Severe** (very marked or prominent, a dramatic change)

1. **Rate the DISTRESS you experience due to that symptoms (how it affects you):**

**0 = Not distressing at all**

**1 = Minimal** (slightly distressing, not a problem to cope with)

**2 = Mild** (not very distressing, generally easy to cope with)

**3 = Moderate** (fairly distressing, not always easy to cope with)

**4 = Severe** (very distressing, difficult to cope with)

**5 = Extreme or Very Severe** (extremely distressing, unable to cope with)

Please answer each question carefully. Ask for assistance if you have any questions.

|  |  |  |
| --- | --- | --- |
| ***Delusions*** | 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? | |
| **Yes No** | **SEVERITY: 1 2 3** | **DISTRESS: 0 1 2 3 4 5** |
|  |  | |
| ***Hallucinations*** | Does the patient have hallucinations such as false visions or voices? Does he or she seem to hear or see things that are not present? | |
| **Yes No** | **SEVERITY: 1 2 3** | **DISTRESS: 0 1 2 3 4 5** |
|  |  | |
| ***Agitation/Aggression*** | Is the patient resistive to help from others at times, or hard to handle? | |
| **Yes No** | **SEVERITY: 1 2 3** | **DISTRESS: 0 1 2 3 4 5** |
|  |  | |
| ***Depression/Dysphoria*** | Does the patient seem sad or say that he/she is depressed? | |
| **Yes No** | **SEVERITY: 1 2 3** | **DISTRESS: 0 1 2 3 4 5** |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| ***Anxiety*** | 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? | |
| **Yes No** | **SEVERITY: 1 2 3** | **DISTRESS: 0 1 2 3 4 5** |
|  |  |  |
| ***Elation/Euphoria*** | Does the patient appear to feel too good or act excessively happy? | |
| **Yes No** | **SEVERITY: 1 2 3** | **DISTRESS: 0 1 2 3 4 5** |
|  |  |  |
| ***Apathy/Indifference*** | Does the patient seem less interested in his/her usual activities or in the activities and plans of others? | |
| **Yes No** | **SEVERITY: 1 2 3** | **DISTRESS: 0 1 2 3 4 5** |
|  |  |  |
| ***Disinhibition*** | 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? | |
| **Yes No** | **SEVERITY: 1 2 3** | **DISTRESS: 0 1 2 3 4 5** |
|  |  |  |
| ***Irritability/Lability*** | Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities? | |
| **Yes No** | **SEVERITY: 1 2 3** | **DISTRESS: 0 1 2 3 4 5** |
|  |  |  |
| ***Motor Disturbance*** | Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly? | |
| **Yes No** | **SEVERITY: 1 2 3** | **DISTRESS: 0 1 2 3 4 5** |
|  |  |  |
| ***Nighttime Behaviors*** | Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day? | |
| **Yes No** | **SEVERITY: 1 2 3** | **DISTRESS: 0 1 2 3 4 5** |
|  |  |  |
| ***Appetite/Eating*** | Has the patient lost or gained weight, or had a change in the type of food he/she likes? | |
| **Yes No** | **SEVERITY: 1 2 3** | **DISTRESS: 0 1 2 3 4 5** |

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For office use only:

Total “No’s”: \_\_\_\_\_\_\_\_\_\_\_

Total Severity: \_\_\_\_\_\_\_\_\_\_

Total Distress: \_\_\_\_\_\_\_\_\_\_

Clinician’s Initials: \_\_\_\_\_\_\_\_