LIFESTAGES FAMILY NEUROHEALTH
COMPREHENSIVE COGNITIVE CARE

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INSTRUCTIONS FOR COMPLETING

Please answer the following questions about your health and history. Although this form is lengthy, it is designed to be very thorough. Completing this information before your appointment will greatly assist the doctor to best use your assessment time with her /him by enabling a more detailed focus.

Name of Patient:_____ Date of Evaluation: _____

If the form is not completed by patient, name of person completing & relationship to

_____ _____
NAME **RELATIONSHIP TO PATIENT**

_____
PHONE NUMBER

DEMOGRAPHICS

STREET:_____ APT. _____

CITY:_____ STATE_____ ZIP:_____

PHONE (Home):_____ Cell:_____

DATE OF BIRTH:_____ Age: _____

SEX: ☐ Male ☐ Female ☐ Non Binary HANDEDNESS: ☐ Right ☐ Left ☐ Ambidextrous

Who is your primary doctor? _____

Address: _____

Phone number:

Fax Number:

May we contact your physician? ☐ Yes ☐ No

REFERRAL INFORMATION:

Who referred you to Lifestages?

- If referred by a specific physician, mental health care provider, or other specialist, please provide his/her name, specialty, and contact information below:

Name: Specialty:

Address:

Phone number:

Fax Number:

INSURANCE INFORMATION:

Insurance Company: ID Number on Card:

Subscriber: Insurance phone: (found on the back of the card)

PRESENTING PROBLEM

Please briefly describe what problem(s) with thinking you are experiencing:

Did these changes have an abrupt onset (for example, normal one day and then problems the next)?

Did these changes have a gradual onset (for example, slowly negatively progressing over time)?

Please describe how long the patient has been experiencing these problems and a brief description of the course (for example, gradual onset starting 3 years ago but a more noticeable decline in the past 6 months).

Have you noticed any of these additional symptoms? Please check those that apply to you.

A. Attention

- [ ] Easily distracted
- [ ] Difficulties staying on task
- [ ] None of the Above

B. Memory

- [ ] Ask same question repeatedly
- [ ] Difficulties with making or keeping appointments
- [ ] Forgetting recent conversations
- [ ] Forgetting why you went into room
- [ ] Forgetting where things are in the kitchen
- [ ] None of the Above

C. Language

- [ ] Trouble summoning words (the word feels like it is on the tip of your tongue)
- [ ] Stopped reading
- [ ] Mispronounce or use wrong words
- [ ] Handwriting has deteriorated
- [ ] Trouble recalling names of long-time acquaintances
- [ ] None of the Above

D. Visuospatial function

- [ ] Confused or disoriented in stores or malls
- [ ] Getting lost easily even on familiar routes
- [ ] Trouble finding the car in the parking lot
- [ ] Difficulty driving: number of accidents and when:
- [ ] None of the Above

E. Executive Function

- [ ] Feeling unorganized
- [ ] Lacking motivation
- [ ] Increased difficulty multitasking
- [ ] Personality changes
- [ ] Embarrassing or inappropriate in social gatherings Difficulties
- [ ] with hygiene-bathroom use
- [ ] Difficulties with negative evaluations at work
- [ ] None of the Above

F. Praxis

- [ ] Difficulties using household items
- [ ] Trouble dressing (two socks on one foot, shirts on backwards)
- [ ] None of the Above

G. Vision

- [ ] Blurred vision
- [ ] Groping for door handles
- [ ] None of the Above

H. Emotional

- [ ] Sadness
- [ ] Anxiousness
- [ ] Social problems
- [ ] None of the Above

What are your typical daily activities? Please respond below.
Would you consider these activities a change from what you used to do?

Do you drive a vehicle?

Activities of Daily Living

TASK	DON'T NEED HELP	NEED HELP	WHO HELPS
Feeding yourself			
Getting from bed to chair			
Getting to the toilet			
Getting dressed			
Bathing			
Using the telephone			
Taking your medicines			
Preparing meals			
Managing money / financial			
Doing laundry			
Doing housework			
Grocery shopping			
Driving			
Doing "handyman" tasks			
Climbing stairs			
Getting to places beyond walking			

Do you employ someone to provide care or help you in your home?

If "yes," how many hours a day? How many days a week?

Do you get help from a family member or friend in your home?

If "yes," how many hours a day? How many days a week?

Do you provide care for a family member?

PAST MEDICAL HISTORY

Please check all medical conditions that you have or have had in the past:

I. EYE & EAR PROBLEMS

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration of the eye
- ☐ Hearing loss/hearing aid
- ☐ Other, specify:

II. HEART PROBLEMS

- ☐ Heart attack: year ____
- ☐ Heart failure
- ☐ High blood pressure
- ☐ Irregular heartbeats (arrhythmias)
- ☐ Aortic stenosis

III. LUNG PROBLEMS

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Other, specify:

IV. BONE & JOINT PROBLEMS

- ☐ Arthritis *(indicate location)*
- ☐ Osteoporosis
- ☐ Gout
- ☐ Fracture

V. GLAND PROBLEMS

- ☐ Diabetes
- ☐ Thyroid (overactive / high)
- ☐ Thyroid (underactive / low)
- ☐ Other, specify:

VI. KIDNEY & URINARY TRACT PROBLEMS

- ☐ Kidney disease
- ☐ Prostate disease
- ☐ Frequent bladder or kidney infections Urinary incontinence
- ☐ Other, specify:

VII. GASTROINTESTINAL PROBLEMS

- ☐ Ulcers
- ☐ Heartburn / hiatal hernia
- ☐ Diverticulosis
- ☐ Liver disease/Cirrhosis
- ☐ Hepatitis
- ☐ Polyps
- ☐ Gallbladder disease
- ☐ Other, specify:

VIII. NERVOUS SYSTEM PROBLEMS

- ☐ Stroke
- ☐ Dementia or Alzheimer's Disease
- ☐ Parkinson's Disease
- ☐ Epilepsy or Seizures
- ☐ Exposure to toxins
- ☐ Head Injury *(# of occurrences :)*
- ☐ *Dates:*
- ☐ *Other (specify):*

IX. OTHER HEALTH PROBLEMS

- ☐ Allergies *(specify)*:
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Hernia
- ☐ Thrombosis (blood clots) ☐ of leg ☐ of lung
- ☐ Sleep Apnea

Treatment:

Cancer *(of what)*

Psychiatric problems:

- ☐ anxiety ☐ depression
- ☐ psychosis ☐ bipolar
- ☐ other *(specify)*

Sexual function problems (specify):

Other, specify:

X. RECENT MEDICAL SYMPTOMS

- ☐ Dizziness
- ☐ Migraines
- ☐ Changes in smell or taste
- ☐ Hallucinations
- ☐ Changes in appetite
- ☐ Loss of urine or getting wet
- ☐ Numbness or arm/leg weakness

Sleep problems *(specify)*

- ☐ Falling asleep ☐ Staying asleep

- ☐ Tremor or Shaking
- ☐ Problems with falling or loss of balance

List surgeries (operations). Use additional page, if needed.

SURGERY	DATE
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

List Other Hospitalizations. Use additional page, if needed.

HOSPITALIZATION REASON	DATE
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

List any neuroimaging (e.g., CT scan, MRI of the head/brain). Use additional page, if needed.

NEUROIMAGING TECHNIQUE	DATE	ORDERING PHYSICIAN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Do you have any drug allergies? _____ specify below

NAME OF DRUG	REACTION
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

List all medicines that you use. (prescription, non-prescription & natural products)

MEDICATION	STRENGTH	HOW OFTEN PER DAY
Example: Tylenol	*500 mg*	*1 pill 3 times a day*
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____

Do you drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?

☐ Daily ☐ Almost daily (4 to 6 times a week) ☐ Never
☐ 1 to 3 times a week ☐ Less than 1 time a week

If you drink alcohol, has anyone ever been concerned about your drinking?

Have you ever sought treatment due to a drinking problem? _____

Have you ever used tobacco? _____ **If "yes,"** are you now smoking? _____

How many years have you smoked? _____
How much do you smoke? *(check all that apply)*
Cigarettes: packs per day E-cigarettes/Vaping: times per day

If you have smoked in the past but are not currently smoking, how many years ago did you quit?
For how many years did you smoke?
How many packs per day did you smoke? _____

Have you ever used illicit/recreational drugs? _____
If yes, please specify type(s) of drugs, frequency of use, and if you currently use illicit/ recreational drugs.

FAMILY HISTORY

Have any members of your family had any of the following conditions? *(check all that apply)*

- ☐ Dementia or Alzheimer's Disease Depression
- ☐ Anxiety
- ☐ Other Psychiatric Problems: *(specify)*:
- ☐ Heart disease
- ☐ Stroke
- ☐ Cancer: type
- ☐ Diabetes
- Other *(specify)*:

SOCIAL HISTORY

Please check the appropriate response for each question below:

With whom do you live?

- ☐ Alone
- ☐ Spouse or partner
- ☐ Child or other family member
- ☐ Others, not family
- ☐ Other, specify:

Which of the following best describes your residence?

- ☐ Single-family house
- ☐ Condo or apartment
- ☐ Live with other in their home
- ☐ Independent living community
- ☐ Board and care/assisted residential care facility
- ☐ Nursing Home
- ☐ Other, specify:

Are you currently:

☐ Married
☐ Widowed
☐ Single / Never married
☐ Divorced / Separated
☐ Living with Significant
☐ Other

Did you or your spouse serve in the military?

How many children do you have? .

Are you in regular contact with your children?

How many years of school did you complete?

☐ Less than 6th grade
☐ Less than High School graduate
☐ High school graduate
☐ Some college
☐ College graduate
☐ Graduate/Professional

Did you attend trade school?

Specify trade:

Is English your primary language?

If no, what is your first language?

Did you go to school in the United States?

If no, where?

Were any subjects more difficult than the others? Which ones?

Did you fail any grades?

What is/was your principal occupation?

Are you currently:

☐ Retired / not working ☐ Working part-time ☐ Working full-time when:

PLANNING FOR FUTURE HEALTH CARE

Do you have a medical Durable Power of Attorney (POA)?

If yes, who is your POA and what is their relation to you?

Do you have a living will?

Do you have any additional information that you would like the doctor to know about before your visit?

_____
_____
_____

EMERGENCY CONTACT

NAME:_____ RELATIONSHIP: _____

PHONE (Home):_____ Cell:_____

Thank you for your cooperation and patience in completing this form!