PATIENT INFORMATION

Name (First, Middle, Last) | Age | Date of Birth

Address | City | State | Zip Code

Home Phone | Cell Phone | Email Address

Emergency Contact — Name / Relationship / Phone Number(s)

Relationship Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Primary Language(s)
☐ English ☐ Spanish ☐ Other:

First language learned
☐ English ☐ Spanish ☐ Other:

Gender
☐ Male ☐ Female ☐ Other:

Ethnic Background
☐ Hispanic ☐ Caucasian ☐ African American
☐ Native American ☐ Asian ☐ Other:

Handedness
☐ Right ☐ Left ☐ Ambidextrous

Highest level of formal education completed
☐ Less than high school ☐ GED
☐ High school ☐ Some college
☐ Associate's degree ☐ Bachelor's degree
☐ Master's degree ☐ Doctoral degree

PERSON COMPLETING PACKET (IF DIFFERENT THAN PATIENT)

Name (First, Middle, Last) | Relationship to patient

☐ Address same as patient

If different: Address / City / State / Zip

Home Phone | Cell Phone | Years you have known the patient

Your age | Today's date | How often do you see the patient?

☐ Every day ☐ 2–3 days/week ☐ 4–6 days/week
☐ Every 2 weeks ☐ Monthly ☐ Less than monthly

About how many hours per week do you spend with the patient?

CONTACT PREFERENCES

Email address | May we send you encrypted email messages? ☐ Yes ☐ No

Preferred contact method ☐ Call ☐ Text ☐ Email | May we leave a voicemail? ☐ Yes ☐ No

Primary contact person — Name | Relationship to patient

Best way to reach primary contact ☐ Home: ☐ Cell: ☐ Email:

POWER OF ATTORNEY

Does the patient have a durable Health Care Power of Attorney? ☐ Yes ☐ No If yes, who is named?

Does the patient have a durable Mental Health Power of Attorney? ☐ Yes ☐ No If yes, who is named?

If yes to either question, please bring a copy of the supporting documents to the initial visit.

PHYSICIANS

Consultation or workup for current symptoms? ☐ Yes ☐ No

If yes — Physician name / Phone number

Primary care physician? ☐ Yes ☐ No If yes — Physician name / Phone number

NEUROPSYCHOLOGICAL EVALUATION HISTORY

Has the patient had a prior cognitive or neuropsychological evaluation (usually 2+ hours of testing of thinking skills)?

☐ Yes ☐ No

If yes — when, where, and by whom

Please bring a copy of any prior evaluation, or sign a release so that we may request it. Neurological records from your referring physician are typically sent to Dr. Husk with your referral.

HEALTH INSURANCE INFORMATION — PLEASE COMPLETE IN FULL

PRIMARY INSURANCE

Insurance Name Member ID# Group #

Policy Holder Name Relationship to policy holder ☐ Self ☐ Spouse/Partner ☐ Dependent

Insurance phone number (from card)

SECONDARY INSURANCE (if none, write N/A)

Insurance Name Member ID# Group #

Policy Holder Name Relationship to policy holder ☐ Self ☐ Spouse/Partner ☐ Dependent

Insurance phone number (from card)

MEDICAL HISTORY

Check below if the patient has experienced any of the following:

- ☐ Head trauma or brain injury
- ☐ Loss of consciousness
- ☐ Stroke or TIA (mini-stroke)
- ☐ Difficulty walking / falls
- ☐ Exposure to toxins
- ☐ Brain infections
- ☐ Seizures
- ☐ Other neurological condition(s):

If you checked any of the above, please describe with date(s):

Early-life injuries or illnesses (birth through adolescence):

History of learning disability or ADD/ADHD? ☐ Yes ☐ No

Ever repeated a grade or received special education? ☐ Yes

If yes to either, please describe

Check if the patient has, or is treated for, any of the following:

- ☐ High blood pressure
- ☐ Atrial fibrillation
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Sleep apnea
- ☐ Other cardiac:

Has the patient had a brain scan (MRI/CT)? ☐ Yes ☐ No

If yes — location / date

Allergies — please list all (medications, foods, other)

MEDICATION HISTORY

Please list all medications taken within the last month. Attach an additional list if needed.

PRESCRIPTION MEDICATIONS

Drug name	Dose	Times per day	Condition being treated

NONPRESCRIPTION MEDICATIONS, SUPPLEMENTS & VITAMINS

Drug name	Dose	Times per day	Condition being treated

PAST AND CURRENT MEDICAL, NEUROLOGICAL & PSYCHIATRIC PROBLEMS

Problem	Diagnosis date	Still active?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

SURGERIES & HOSPITALIZATIONS

Surgery or reason for hospitalization	Hospital	Date

SOCIAL HISTORY

Retired? ☐ Yes ☐ No If yes, year retired:

Primary / longest-held occupation

Hobbies / interests

Do or did memory or thinking problems affect working or hobbies? ☐ Yes ☐ No

Number of children

Current living situation

☐ Alone in home/apt
☐ With spouse/partner
☐ With other family or friends
☐ Assisted living
☐ Nursing home
☐ Other:

SUBSTANCE USE HISTORY

TOBACCO USE

Currently smoke? ☐ Yes ☐ No Packs per day: Years smoked:

Ever smoked in the past? ☐ Yes ☐ No Packs per day: Years smoked:

Year quit:

ALCOHOL USE

Current use — drinks per week:

Past use — drinks per week:

History of excess use (now or in the past)? ☐ Yes ☐ No

OTHER SUBSTANCE USE

Medical marijuana, recreational drugs, or misused prescription medications — recently and/or in the past?

☐ Yes ☐ No

If yes — type / duration

FAMILY HISTORY

Does the patient have a blood relative with symptoms of, or a diagnosis of, any of the following?

Dementia / Alzheimer·s disease? ☐ Yes ☐ No

If yes · relationship and age of onset of memory problems

FAMILY HISTORY (CONTINUED)

Parkinson·s disease? ☐ Yes ☐ No

If yes, relationship:

Strokes? ☐ Yes ☐ No

If yes, relationship:

Psychiatric / mental illness? ☐ Yes ☐ No

If yes, relationship:

Intellectual disability? ☐ Yes ☐ No

If yes, relationship:

Number of brothers: Number of sisters: Living siblings without dementia? ☐ Yes ☐ No

Other significant illnesses in the family (not checked above)

CURRENT PROBLEM

What is the main reason for the visit?

What were the initial symptoms, and when did they first develop?

Did the symptoms begin ☐ Suddenly ☐ Gradually

How have the symptoms changed over time?
☐ Stable ☐ Stable, then sudden decline ☐ Steadily worsened
☐ Fluctuating ☐ Improved

Delirium — periods of extreme confusion or disorientation due to illness, medication side effects, or hospitalization?

☐ Yes ☐ No ☐ Don't know

If yes — approximate year(s) and describe the event(s)

MEMORY & THINKING — DOES SHE/HE HAVE PROBLEMS WITH:

	Never/Rarely	Sometimes	Often	Always
Recalling recent events or 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 an unfamiliar place	☐	☐	☐	☐
Becoming lost or confused in familiar places	☐	☐	☐	☐
Finding words or expressing thoughts	☐	☐	☐	☐
Understanding others	☐	☐	☐	☐
Making judgments or solving problems	☐	☐	☐	☐
Carrying out multi-step activities	☐	☐	☐	☐
Multitasking (two tasks at one time)	☐	☐	☐	☐
Focusing, concentrating, or being easily distracted	☐	☐	☐	☐

DAILY TASKS — PROBLEMS RELATED TO MEMORY & THINKING CHANGES

Check N/A if the person has never performed the task or you do not know.

	N/A	Never/ Rarely	Sometimes	Often	Always
Medications					
Preparing / organizing medications	☐	☐	☐	☐	☐
Recalling use and/or dosage	☐	☐	☐	☐	☐
Forgetting to take medications	☐	☐	☐	☐	☐
Making other medication errors	☐	☐	☐	☐	☐
Finances					
Preparing / completing taxes	☐	☐	☐	☐	☐
Paying bills on time	☐	☐	☐	☐	☐
Managing checkbook / accounts	☐	☐	☐	☐	☐
Handling money (e.g., 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 (phone, microwave, thermostat, computer,	☐	☐	☐	☐	☐

PERSONAL CARE AND GROOMING — LEVEL OF INDEPENDENCE

	Completely independent	Verbal reminders	Physical assistance	Completely d
Shaving	☐	☐	☐	☐
Combing / styling hair	☐	☐	☐	☐
Brushing teeth	☐	☐	☐	☐
Bathing or showering	☐	☐	☐	☐
Dressing or undressing	☐	☐	☐	☐
Eating using utensils	☐	☐	☐	☐
Chewing and swallowing safely	☐	☐	☐	☐
Using the toilet	☐	☐	☐	☐

SYSTEM REVIEW — CHECK "YES" FOR ANY SYMPTOMS THE PATIENT IS CURRENTLY EXPERIENCING

This brief review covers the body systems most relevant to cognitive health. Anything else can be discussed at your visit.

NEUROLOGICAL	PSYCHIATRIC / CARDIOVASCULAR	METABOLIC / ENDOCRINE / OTHER
Dizziness	Anxiety	Excessive thirst
Numbness in extremities	Depression	Excessive eating
Weakness in extremities	Insomnia	Heat or cold intolerance
Walking / balance problems	Chest pain	Hair changes
Headache	Leg pain when walking	Unexplained weight change
Memory loss	Swelling in legs/feet	Shortness of breath
Seizures / convulsions	Palpitations	Urinary incontinence
Tremors		Bowel incontinence
Fainting		Falls in the past year

JUDGMENT AND SAFETY

- ☐ Leaving the stove on
- ☐ Leaving the water on
- ☐ Trouble regulating the thermostat
- ☐ Access to weapons or power tools
- ☐ Wandering off or getting lost
- ☐ Forgetting to eat
- ☐ Unsafe living alone / being left alone
- ☐ Susceptible to solicitors or scams

Does the person currently drive a motor vehicle? ☐ Yes ☐ No

If yes, are you concerned about driving safety? ☐ Yes ☐ No

If concerned, check any areas of concern

- ☐ 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 over curbs
- ☐ Doesn't pay attention
- ☐ Other:

SLEEP, PERSONALITY & SYSTEM REVIEW

SLEEP — CHECK ANY PROBLEMS

- ☐ "Acting out dreams" (punching, flailing, shouting)
- ☐ Legs jerking/twitching during sleep
- ☐ Restless, tingly, creepy-crawly legs
- ☐ Walking around while asleep
- ☐ Snorting or choking awake
- ☐ Seems to stop breathing during sleep
- ☐ Increased need for sleep
- ☐ Excessive daytime sleepiness
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

PERSONALITY — LIFE-LONG TRAITS

- ☐ Even tempered
- ☐ Quick tempered
- ☐ Optimistic
- ☐ Pessimistic
- ☐ Socially outgoing
- ☐ Homebody
- ☐ Worrier
- ☐ Stubborn
- ☐ Low self-esteem
- ☐ Assertive
- ☐ Manipulative
- ☐ Complainer
- ☐ Hypochondriac
- ☐ Generous/caring
- ☐ Good sense of humor

PERSONALITY CHANGES

- ☐ Increased impulsivity
- ☐ Reduced frustration tolerance
- ☐ Increased irritability
- ☐ Agitation
- ☐ Difficulty getting started
- ☐ Reduced motivation
- ☐ Loss of empathy
- ☐ Socially inappropriate behavior
- ☐ Restlessness
- ☐ Risky behaviors
- ☐ Social withdrawal
- ☐ Other, describe:

CAREGIVER CONCERNS — IF YOU ARE A CAREGIVER, WHICH AREAS CONCERN YOU?

- ☐ Financial / legal
- ☐ Physical health
- ☐ Mental health
- ☐ Managing problem behaviors
- ☐ Decisions about care options
- ☐ Other