ROCKY MOUNTAIN
Memory Center

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Rocky Mountain Memory Center

PATIENT HISTORY

Clinical History

What issues brings you in for evaluation (Please circle all that apply):

Attention Deficit; Memory Loss; Cognitive Inefficiency; Neurological Disorder; Chronic Pain; Neuromotor (falls, imbalance, ect.), Insomnia; Mood Disorder ; Other

Describe Briefly

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____

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____

Onset Date: ____

Severity Level: Mild Moderate Severe

Progression: Rapid Gradual

Frequency of Episodes: Daily Weekly Infrequent

COGNITION

Amnestic type memory loss or forgetting what was said after <u>very brief time</u>: Yes; No
Explain: ____

Inability to recall conversations, appointments or details at the end of the day or next day: Yes; No

Explain: ____

Easily distracted, unable to complete thoughts: Yes; No
Explain: ____

Tends to repeat self or ask the same question over and over: Yes; No
Explain: ____

History of prior diagnosis or problem with attention or learning disorder: Yes; No
Explain: ____

Fluctuations in cognition or alertness from day to day or throughout day: Yes; No
Explain: ____

Episodes of confusion or disorientation: Yes; No
Explain: ____

Inability to work TV remote, front door keys, fender benders, easily getting lost: Yes; No
Explain: ____

Problems with word recall or names: Yes; No
Explain: ____

Getting lost while driving: Yes; No
Explain: ____

Inability to follow instructions: Yes; No
Explain: ____

NEUROLOLOGICAL

Neurological Consult: Have you ever seen a neurologist? Yes No
If Yes: Date: ____________________ Neurologist: ______________________
Reason: ____

Head Neuroimaging: Have you ever had a head CT scan or Brain MRI?: Yes No
If yes: Date: ___________________ Location:_____________________
Reason: ____

Head Injury: Have you ever had a head injury? Yes No
Circumstance: ____
Are you currently in the process of litigation resulting from your head injury? Yes No
If yes, please describe: ____

Diagnosis of MS: Yes; No: ____

Diagnosis of Parkinson's disease: Yes; No: ____

Imbalance: Yes; No ____

Falls: Yes; No ____

Chronic fatigue: Yes; No ____

Impaired alertness/arousal level: Yes; No ____

General weakness: Yes; No ____

Loss of consciousness: Yes; No ____

Tremor: Yes; No ____

Trouble swallowing: Yes; No ____

Extreme motor slowing: Yes; No ____

Seizures/Epilepsy: Yes; No ____

SLEEP DISORDER

Trouble getting to sleep: Yes: No ____

Light sleeper, trouble staying sleep or easily awakened: Yes; No _______________________________

Snoring: Yes; No
If so, how loud is your snoring? Not as loud as talking / Louder than talking
How often do you snore? Nearly every day / 3-4x a week / 1-2x a week

Have you ever noticed that you quit breathing during your sleep? Yes; No
If so, how often do you notice? Nearly every day / 3-4x a week / 1-2 x a week

Talks or walks in sleep: Yes; No ____

Vivid dreams/ acts out dreams; Yes; No ____

Restless legs; Yes; No____

Feels foggy headed or tired upon awakening: Yes; No ____

Do you have trouble staying awake during the day: Yes; No ____________________________

Do you take naps: Yes; No ____________________________

On a scale of 1-10 how tired are you during the day: ____________________________

Have you been diagnosed with sleep apnea; Yes; No: ____________________________
Sleep study: Where: ____________________ Year: ____________________

Do you wear a CPAP/BiPAP: Yes; No ____________________________

CHRONC PAIN

Chronic Pain Disorder: Yes; No Type: ____________________________

Fibromyalgia: Yes; No ____________________________

Migraines: Yes; No ____________________________

Frequency: ____________________ Severity: ____________________

Peripheral Neuropathy: Yes; No ____________________________

Cervical/Back pain: Yes; No ____________________________

NEUROBEHAVIORAL

Acute change in mood: Yes; No ____________________________

Suspiciousness/ Paranoia: Yes; No ____________________________

Reactive Anxiety/ Agitation: Yes; No ____________________________

Auditory or Visual Hallucinations: Yes; No ____________________________

Systematized delusions: Yes; No ____________________________

Abulia/ Lack of spontaneity / inertia/ lack of get up and go: Yes; No ____________________

GENERAL HEALTH

Do you have any major, chronic health conditions? Y N
(If you answered yes, please list them.)

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________

Eye glasses: Yes: No ____________________________

Hearing loss: Yes: No ______________ Hearing aids: Yes No ____________________

Walks: Independently cane walker

Dominant Hand: Right Left

High Cholesterol: Yes; No: ____________________

Hypertension: Yes; No: ____________________

Diabetes/Prediabetes : Yes; No: ____________________

Respiratory Disease: Yes; No: ____________________
Daytime Oxygen: Yes; No: ____________________

Heart Disease / Heart attack: Yes; No: ____________________

TIA/Stroke: Yes; No: Year: ____________________

Dizziness: Yes; No: ____________________

Vertigo/vestibular problem: Yes; No: ____________________

Orthostatic hypotension: Yes; No: ____________________

Syncope/unexplained falls: Yes; No: ____________________

Incontinence: Yes; No: ____________________

Constipation: Yes; No: ____________________

Are you currently taking any medications for **medical conditions**? **Y** **N**

	Medication 1	**Medication 2**	**Medication 3**
Drug Name	________	________	________
For what problem	________	________	________
Dose	________	________	________
	Medication 4	**Medication 5**	**Medication 6**
Drug Name	________	________	________
For what problem	________	________	________
Dose	________	________	________

Childhood

Where were you born and raised? ____

What was your father's job? ____

What was your mother's job? ____

Were you adopted? Y N

If yes, what was your age at the time? ______________________

Temperament Risk Factors

As a child or adolescent, did your parents or others describe you as having, or being any of the following?

Difficulty with social cues and non verbal language	Yes	No
Impulsive	Yes	No
Difficulty making decisions	Yes	No
Accident prone, clumsy	Yes	No
Trouble relating to and socializing with peers	Yes	No
Irritable	Yes	No
Dislikes changes in plans or routines, needs sameness & routines	Yes	No
Cries easily, very emotional and sensitive	Yes	No
Frequent temper tantrums	Yes	No
Eating problems	Yes	No
Sleep problems	Yes	No
Stubborn, uncooperative	Yes	No
Oppositional/defiant	Yes	No
Difficulty with authority figures	Yes	No
Impatient	Yes	No
Easily frustrated	Yes	No
Strong feelings of anger or rage	Yes	No
Unpredictable moods	Yes	No
Inflexible or rigid in thinking	Yes	No
Separation anxiety	Yes	No
Is sensitive to light, noise, clothes or touch	Yes	No
Tired, sluggish, slow moving	Yes	No
Periods of panic or fear for no reason	Yes	No

Tendency to get locked into negative thoughts	Yes	No
Worries excessively or senselessly	Yes	No
Panic attacks	Yes	No
Super organized	Yes	No
Social anxiety or phobias	Yes	No

Is there anything else that may have described you as a child or adolescent?

____

Environmental Risk Factors

As a child or adolescent, did you experience any of the following?

Significant loss or separation from a loved one	Yes	No
Sexual abuse	Yes	No
Physical abuse	Yes	No
Emotional abuse	Yes	No
Violence in the family	Yes	No
Neglect	Yes	No
Extreme family stress	Yes	No
Economic problems/poverty/financial stress	Yes	No
Poor diet	Yes	No
Did you experience any other traumas during your childhood? (If yes, please describe on the lines provided below.)	Yes	No

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Medical Risk Factors

Encephalitis, meningitis	Yes	No
Fainting spells/blackouts	Yes	No
Frequent emergency room visits	Yes	No
Hospitalized for any reason	Yes	No
Loss of consciousness	Yes	No
Seizures	Yes	No

Attention Deficit Risk Factors

As a child or adolescent, did you experience any of the following?

Trouble sitting still, in constant motion	Yes	No
Risk taker/daredevil	Yes	No
Daydream excessively	Yes	No
Bored easily	Yes	No
Don't think through comments or actions before they are said or done	Yes	No
Unorganized	Yes	No
Can't seem to finish anything	Yes	No
Lose things	Yes	No
Absent minded, spacey	Yes	No
Lacks self confidence	Yes	No
Talks too much	Yes	No
Trouble with time, is frequently late or hurried, tasks take longer than expected	Yes	No
Trouble getting started on a task	Yes	No
Sometimes attention narrows so much that I become oblivious to everything else	Yes	No
Trouble with planning ahead	Yes	No
Things I see or hear distract me from what I'm doing	Yes	No
I have trouble listening to what other people are saying	Yes	No

Academic History

During elementary/ middle school, high school were you in general (choose one)

a) usually above grade level b) average – working at grade level

c) below grade level d) needing extra help

During school, did any of the following ever happen to you?

Failed any grades	Yes	No
Retained in grade	Yes	No
Took special classes	Yes	No
Evaluated by school	Yes	No
Labeled by school	Yes	No
Had learning difficulties		

Received tutorial assistance	Yes	No
Suspended from school	Yes	No
Expelled from school	Yes	No
Reading problems	Yes	No
Arithmetic problems	Yes	No
Writing problems	Yes	No
Performance was variable or unpredictable	Yes	No
Told you weren't achieving up to your potential	Yes	No
Told you had a learning disability	Yes	No

Did any other significant events occur during elementary school? (If yes, please describe on the lines provided below.)

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Psychiatric History

As a child or adolescent, did you ever see a professional such as a counselor, psychologist, or psychiatrist for any reason?

	Provider 1	Provider 2	Provider 3
For what problems?			
What kind of professional?			
Professional's name			
Age started			
Age stopped			
How often?			
Benefits			
Reason for stopping			

As a child or adolescent, did you take medication for any psychological/psychiatric problems?

	Medication 1	Medication 2	Medication 3
Drug name			
Prescribed by			
Age started			
Age stopped			
For what problems?			
Total daily dose			
Benefits			
Side effects			

Family History Risk Factors

Is there anyone in your immediate family (e.g., parents, brothers, sisters or your children) who you think may have the following psychological, psychiatric or attentional disorders, whether or not they were ever diagnosed or treated?

Disorder	Present?		Relation to Patient
Depression	Y	N	
Manic depression/Bipolar Disorder	Y	N	
Anxiety or lots or worrying	Y	N	
Alcohol abuse	Y	N	
Other substance abuse	Y	N	
Conduct problems or trouble with the law	Y	N	
Learning problems	Y	N	
Attention Deficit Disorder	Y	N	

Educational /Occupational Information

Did you attend or are you attending any post-high school education (e.g., college or technical school)? YES No

School	Dates	Major	GPA	Graduated?	Degree Obtained
________	________	________	________	________	________
________	________	________	________	________	________

What were your most recent jobs?

Job	Dates	Job Duties	Why/how ended?
________	________	________	________
________	________	________	________
________	________	________	________

Social History

Have you ever been married? **Y** **N**

If yes, to whom?

Partner's Name	Dates	Why/how ended?
________	________	________
________	________	________

List names of children

Name	Location	Current Age
______________________	______________________	__________
______________________	______________________	__________
______________________	______________________	__________
______________________	______________________	__________
______________________	______________________	__________

Adult Psychological/Psychiatric History

As an adult history of sexual, physical or emotional abuse? Yes No

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Have you ever, as an adult, had a period of time when you were:

Feeling depressed or sad more often than not, or found that you could not enjoy things you used to enjoy? Yes; No

Feeling a lot of anxiety or tension or worry all the time about things – more so than other people? Yes; No

Do those close to you complain that you have a hot temper or a short fuse? Yes: No

Do you have rapid, brief moods swings? Yes; No

Are there any major stressors occurring in your life right now? Yes; No

If you answered yes to the previous question, please list the stressors:

1. ____

2. ____

3. ____

As an adult, have you seen a counselor, psychologist, or psychiatrist for any reason? Yes; No

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Lifestyle

Lifestyle: Height: ______. Weight: ______.

Dietary/Nutritional Habits: ____

Physical activity level:

- Type of exercise: ____
- Frequency: ____

Social

- Activities, groups, clubs: ____

Mental stimulation

- ____

Engage in regular religious, spiritual or meditation practice: ____________________

Do you, or did you, use any of the following substances?

Substance	**Use**	**Age of first use**	**Age of last use**	**Age of heaviest use**	**Heaviest usage (amount per day)**	**Current usage (amount per day)**
Alcohol	Y N					
Cigarettes	Y N					
Coffee/tea/coke /soda	Y N					