CMA The Center For Memory and Aging

Patient Questionnaire

PLEASE FILL OUT THE FOLLOWING INFO AS COMPLETELY AS POSSIBLE:
(If difficult, please have accompanying friend or family member help you.)

Today's Date ______________________

Patient Name ____

Sex (M or F) _____ Age________ Date of Birth__________ Marital Status________________________

Spouse Name (if applicable) ____

Home Address ____City ____________________________

State_____________ Zip Code_________________ Home Phone ______________________________

Work Phone _________________________________ Cell Phone ______________________________

Email Address (if applicable) __________________________ Referred by ________________________

Social Security Number __________________________ Drivers License ___________________________

Employer (if applicable) _____________________________ Occupation __________________________

Have you been seen here in this office before? ____________When (Year) _______________________

Insurance Information:

Health Insurance Company ______________________ Alternate Insurance Plan _____________________

Name of Insured ____________________________________

Please have your insurance and/or Medicare card(s) ready for the receptionist to make a copy for your chart records.

Responsible Party other than Patient:

Name _____________________________ Address ____

City __________________________________ State _________________________ Zip _____________

Phone ________________________________

Do you want this person to also discuss your medical care with your doctor? ________________
Initial here _______

Other Contact:

Friend / Relative not living with patient in case of emergency ___________________________________

Phone _________________________ Relation to patient _______________________________________

The person signing this form authorizes the doctor(s) at the CMA and PCND, Inc. to treat the patient and obliges them to pay for services rendered unless prior agreements made. Fees are payable upon services rendered. Please ask our receptionist if there are any questions. I HAVE READ AND CONSENT FOR TREATMENT AND PAYMENT TO PCND, INC. I AUTHORIZE MEDICAL BILLING INFORMATION TO BE RELEASED TO MY INSURANCE COMPANY.

Patient Signature ____ **Date** ______________________

OTHER INFORMATION

Primary Physician Information:

Primary Physician / Medical Group ______________________________

Office Address ______________________________City ______________________________

State ______________________________ Zip Code ______________________________

Office Telephone ______________________________ Office Fax ______________________________

Physician Email Address (if applicable) ______________________________

General Information

What is the primary language spoken at home? ______________________________

What was the first language learned? ______________________________

Is the patient right-handed, left-handed, or ambidextrous? ______________________________

General Medical History

Have you had any neuroimaging (e.g., EEG/MRI/FMRI/CT)? **Yes / No** If yes, please bring reports if available.

Do you drive currently? **Yes / No** If yes, have there been any incidents in the past two years (e.g., confusion/lost/ticket/accident)? Please explain: ______________________________

____

Describe your use of alcohol/tobacco/recreational drugs: ______________________________

____

____

List your current medications: ______________________________

____

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Symptom Survey Chart

Please place a mark (X) next to each symptom that applies, and note date of onset if possible:

	Date of Onset / Comment
Physical concerns	
☐ Headaches	
☐ Dizziness	
☐ Balance problems	
☐ Urinary problems	
☐ Bowel problems	
☐ Strength problems	
☐ Motor problems	
☐ Other physical concerns?	
Sensory concerns	
☐ Numbness	
☐ Tingling	
☐ Visual impairment	
Do you wear glasses? ☐ Yes ☐ No	
☐ See things that are not there	
☐ Hearing impairment	
Wear hearing aid? ☐ Yes ☐ No	
☐ Problems with taste or smell?	
☐ Other sensory concerns?	

Intellectual concerns	Date of Onset / Comment
Problem Solving	
☐ Difficulty figuring out how to do new things	
☐ Difficulty figuring out problems that most others can do	
☐ Difficulty planning ahead	
☐ Difficulty changing a plan or activity when necessary	
☐ Difficulty thinking as quickly as needed	
☐ Difficulty doing things in the right order (sequencing)	
Language and Math Skills	
☐ Difficulty finding the right word	
☐ Slurred speech	
☐ Difficulty expressing thoughts	
☐ Difficulty understanding what others say	
☐ Difficulty understanding what I read	
☐ Difficulty writing letter or words (not due to a motor problem)	
☐ Difficulty with math (e.g., balancing checkbook, making change)	
☐ Other language or math problems?	
Nonverbal skills	
☐ Difficulty telling right from left	
☐ Difficulty drawing or copying	
☐ Difficulty dressing	
☐ Difficulty doing things I used to do automatically (e.g., brushing teeth)	
☐ Difficulty find way around familiar places	
☐ Difficulty recognizing objects or people	
☐ Difficulty decline in my musical abilities	
☐ Not aware of time	
☐ Slowed reaction time	
☐ Other nonverbal problems?	
Awareness and Concentration	
☐ Highly distractible	
☐ Lose my train of thought easily	
☐ Mind goes blank a lot	
☐ Difficulty doing more than one thing at a time	
☐ Easily confused and disoriented	
☐ Don't feel very alert or aware of things	
☐ Tasks require more effort or attention	
Memory	
☐ Forget where I leave things (e.g., keys, purse, etc.)	
☐ Forget names	
☐ Forget what I should be doing	
☐ Forget where I am or where I am going	
☐ Forget recent events	
☐ Forget appointments	
☐ Forget events that happened long ago	
☐ Forget the order of events	
☐ Forget facts but can remember how to do things	
☐ Forget faces of people I know	

	Date of Onset / Comment
☐ More reliant on others to remind me of things	
☐ More reliant on notes to remember things	
☐ Other memory problems?	
Mood/Personality	
☐ Sadness and depression	
☐ Anxiety or nervousness	
☐ Stress	
☐ Sleep problems	
☐ Excessive snoring	
☐ Become angry more easily	
☐ Euphoria (feeling on top of the world)	
☐ Much more emotional	
☐ Feel as if I just don't care anymore	
☐ Easily frustrated	
☐ Less inhibited (do things I would not do before)	
☐ Difficulty being spontaneous	
☐ Change in energy? ☐ Loss ☐ Gain	
☐ Change in appetite? ☐ Loss ☐ Gain	
☐ Change in weight? ☐ Loss ☐ Gain ______ lbs./year	
☐ Change in sexual interest	
☐ Lack of interest in pleasurable activities	
☐ Increase in irritability	
☐ Increase in aggression	
☐ Other changes in mood or personality or in how you deal with people?	

Overall, my symptoms have developed? ☐ Slowly ☐ Quickly
Over the past six months my symptoms have: ☐ Improved ☐ Stayed the same ☐ Worsened
Is there anything you can do (or someone does) that gets the problems to stop, to be less intense, less frequent, or shorter? ____

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What seems to make the problem worse?
____
____

Please indicate if you have a history of any of the following. If yes, please describe briefly:

☐ Head injury? ____________________________
☐ Hypertension?
☐ Heart Disease? ____________________________
☐ Stroke? ________________________________
☐ Seizure? ________________________________
☐ Other Neuro Disorder? ____________________
☐ Psychiatric Disorder? _____________________

☐ Cancer? ____________________________
☐ Headaches?
☐ High Cholesterol?
☐ Diabetes?
☐ Kidney Problems? ____________________
☐ Surgeries? ____________________________
☐ Other (e.g., thyroid problem, menopause, etc)?

Family History

The following questions deal with your biological mother, father, brothers, and sisters:

Is your mother alive? ☐ Yes ☐ No Mother's highest level of education: ____________________
If deceased, what was the cause of her death? ____________________________________
Is your father alive? ☐ Yes ☐ No Father's highest level of education: ____________________
If deceased, what was the cause of his death? ____________________________________

Please describe any parental family history of:

Neurological diseases (e.g., Parkinson's, Alzheimer's, multiple sclerosis): ______________________________

____

Psychiatric conditions (e.g., depression, anxiety, bipolar illness, schizophrenia): __________________________

____

Other disorders (e.g., problems with attention, learning, speech/language, or behavior): ____________________

____

How many brothers and sisters do you have and what are their ages? __________________________________

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Are there any unusual problems (physical, academic, psychological) associated with any of your brothers or sisters? If yes, please describe: ____

____

Social and Occupational History

Grade/degree completed in school: _________________________________

Were you involved in special education? Yes No

Are you married? • Yes • No How long? _____________________________

With whom do you currently live? _________________________________

Do you have children? Yes No Ages? ______________________________

Are you unemployed, employed, or retired? _________________________

Describe any legal problems you have had: ____

How do you spend your time?

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Is there any other information you would like to add?

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