Assessment of Cognitive Complaints Toolkit for Alzheimer's Disease: pre-visit informant questionnaire v.27

PATIENT NAME:
DATE OF BIRTH:
DATE:
RACE: PRIMARY LANGUAGE: YEARS OF EDUCATION:
NAME OF PERSON COMPLETING QUESTIONNAIRE: (If other than patient. Please respond to questions on behalf of patient above.) _____
RELATIONSHIP TO PATIENT: _____ How often do you spend time with patient: Daily☐ Weekly☐ Monthly☐ Every 3 month☐ Every 6 month☐ Yearly☐

This questionnaire will assist the medical team in completing the patient's evaluation.
Please:

- Answer these questions honestly and to the best of your ability.
- Be specific. For example, "Last Tuesday, my loved one got lost on the way home from the store. It was scary."

In addition to the questions below the medical provider may also ask details about:

- Past and current medical problems and surgical history
- Family medical history
- The patient's social history
- All medications that the patient is currently taking including: prescription medications, over-the-counter vitamins, aspirin, etc. herbal supplements,
- Past or present use of: alcohol, marijuana (CBD/THC) or other social drugs such as stimulants, narcotics, or sedatives.

Question: (check all that apply)	YES	Please provide additional comments if necessary:
Has the patient had any changes in their ability to manage basic activities of daily living due to changes in memory or thinking?		
The patient requires help to bathe.		
The patient requires help to dress.		
The patient is not able to manage their bladder and bowels without accidents		
Has there been a change in the patient's ability to manage their household due to problems with memory or thinking?		
The patient requires help to manage their own shopping.		
The patient requires help to pay their bills on time.		
Is the patient requiring help to complete household chores or projects		
The patient has left the stove on.		

Question: (check all that apply)	YES	Please provide additional comments if necessary:
The patient requires help to follow recipes.		
The patient is not able to drive.		
The patient is having trouble completing tasks at work.		
The patient has lost their job because of trouble completing tasks at work.		
The patient has difficulty answering the phone		
The patient is unable to do their laundry		
The patient is unable to manage their transportation (Example: taking the bus, calling a cab, etc.)		
The patient cannot manage their finances (Example: checking account, retirement account, banking)		
Does the patient have any problems with memory?		
Does the patient misplace items often (e.g., phone, keys)?		
Does the patient rely more on notes?		
Does the patient have trouble with recent memory (conversations, recent events) compared to remote memory?		
Does the patient ask repetitive questions?		
Does the patient have difficulty expressing words, difficulty understanding words or conversations?		
Does the patient have difficulty finding the word or name they want to use?		
Does the patient have difficulty understanding what people are saying to them?		
Does the patient have any difficulty pronouncing words that were easy for them to pronounce in the past?		
Does the patient have difficulty planning, starting, or finishing complicated tasks at home or at work?		
Does the patient have difficulty keeping their home or office as neat and organized/clean as it used to?		
Does the patient have problems finishing a task because they get distracted easily?		
Does the patient get lost while walking or driving?		
Does the patient have difficulty driving to familiar places (walking or driving) i.e., grocery store, post office, friend's house, etc?		
Does the patient get lost in a familiar store or restaurant?		

Question: (check all that apply)	YES	Please provide additional comments if necessary:
Does the patient have difficulty seeing things properly or judging distances properly?		
Does the patient's motor vehicle show evidence of damage?		
Does the patient have difficulty figuring out how to position themselves to sit in a chair?		
Does the patient complain of difficulty seeing while reading?		
Does the patient complain that their eyes do not work?		
Does the patient have trouble seeing things that are right in front of them?		
Does the patient have difficulty recognizing people?		
Has the patient's mood changed?		
Does the patient cry a lot?		
Does the patient feel hopeless about life or about the future?		
Does the patient feel worthless or bad about themselves?		
Has the patient lost motivation or energy to do things they used to enjoy?		
Does the patient have decreased interest in social activities?		
Does the patient have decreased interest in church or community groups?		
Does the patient have decreased interest in hobbies?		
Does the patient become angry more easily?		
Does the patient get angry about things that would not have bothered them in the past?		
Sometimes we have patients who seem to forget how to behave in public. Has this been an issue for the patient?		
Has the patient done anything that may have been embarrassing to the family? e.g., calling people fat in public when they might hear?		
Has the patient ever told dirty jokes in inappropriate situations?		
Has the patient ever told personal things about themselves or family to strangers?		
Has the patient ever eaten from other people's plates at restaurants?		
Has the patient had any problems with beliefs that are unusual or not realistic?		

Question: (check all that apply)	YES	Please provide additional comments if necessary:
Does the patient feel like someone is out to get them?		
Does the patient feel like they might have special powers or special relationships with famous or powerful people		
Has the patient been seeing or hearing anything that might not be there (or others can't see or hear)?		
Has the patient become fixated on certain ideas that they can't get out of their head or have developed any specific rituals?		
Does the patient have any obsessions with certain political or religious ideas?		
Does the patient have any obsessions about timing or routine being adhered to precisely?		
Does the patient have any obsessions with specific games, movies or specific forms of entertainment?		
Does the patient have any changes in sleep?		
Does the patient wake up a lot in the middle of the night?		
Does the patient have problems falling sleep?		
Has the patient's partner reported that the patient may have problems acting out dreams (yelling, screaming, hitting)?		
Does the patient snore?		
Has the patient's partner ever reported that the patient may have breathing stoppages while they sleep?		
Is the patient sleepy during the day?		
Have there been changes in the patients eating habits?		
Has the patient been eating more or less than usual?		
Has the patient had any unintentional weight gain?		
Has the patient had any unintentional weight loss?		
Does the patient want to eat specific foods all the time?		
Does the patient want to eat sweets or carbohydrates more than they used to?		
Does the patient seem less concerned about others' needs, problems?		
Do you feel the patient does not react appropriately in an emergency or when someone needs help?		
Do you feel the patient does not react emotionally when someone has a particularly sad or happy event (e.g., a loss or major achievement)?		
Does the patient seem to be more open to scams or solicitations?		

Question: (check all that apply)	YES	Please provide additional comments if necessary:
Has the patient been buying lots of magazines or online offers?		
Has the patient ever been fooled by a suspicious business arrangement?		
Does the patient have involuntary shaking in their hands, arms, legs, or chin?		
Does the patient's limbs feel rigid or stiff?		
Is the patient able to turn their head and neck easily?		
Have the patient's movements been slowing down?		
Is the patient walking slower?		
Does it take the patient longer to button their shirt?		
Is the patient's handwriting smaller?		
Has the patient had changes in their ability to walk?		
Is the patient stooped over when walking?		
Does the patient drag their feet when they walk?		
Is the patient's steps shorter or do they get stuck when walking?		
Has the patient fallen in the past couple of years?		
If yes, how many times has the patient fallen?		
What were the circumstances of the patient's falls? (Tripping, weakness of legs, loss of consciousness, unsteadiness)		
Does the patient feel unsteady on their feet?		
Is the patient weaker on one side of their body than the other?		
Has the patient had a stroke?		
Does the patient have trouble using one hand?		
Does the patient limp or drag one foot?		
Does the patient have involuntary movement of your limbs, such as jerking or twitching?		
Has the patient had changes to their muscles?		

Question: (check all that apply)	YES	Please provide additional comments if necessary:
Has the patient lost muscle mass?		
Are the patient's muscles weaker?		
Has any of the patient's muscles become smaller?		
Does one of the patient's arms behave as if it does not belong to them?		
Has the patients arm unbuttoned their shirt or grabbed something without their awareness or control?		
Does the patient have slurring of their speech?		
Does the patient's speech sound as if they are drunk?		
Does the patient have trouble swallowing?		
Does the patient cough or choke when eating or drinking?		
Has the patient had any other difficulty swallowing liquids or solid foods?		
Are there any members of the patient's family with "mental health problems, dementia, Parkinson's or other neurological problems"? For example: Alzheimer's disease, Parkinson's, schizophrenia, bipolar, depression.		

Thank you for completing the cognitive complaints patient questionnaire. Your input is very valuable for a thorough evaluation. Please feel free to provide the patient's physician further information below if necessary.