EMORY
BRAIN HEALTH CENTER

Integrated Memory Care Clinic
12 Executive Park Drive, NE
5th floor
Atlanta, GA 30329
Phone 404-712-6929

NEW PATIENT INFORMATION

Name:_____ Date of Birth:_____

Preferred Name:_____ SSN:_____

Race: _____ Highest Level of Education: _____

Address: _____

City:_____State:_____Zip Code: _____

Email: _____

Telephone: (h)_____ (w)_____ (cell)_____

Communication Needs: _____

Family Contact:

Name:_____Relationship to patient:_____

Address: _____

City:_____State:_____Zip Code: _____

Email: _____

Telephone: (h)_____ (w)_____ (cell)_____

Emergency Contact:

Name:_____Relationship to patient:_____

Address: _____

City:_____State:_____Zip Code: _____

Email: _____

Telephone: (h)_____ (w)_____ (cell)_____

Primary Caregiver (if other than Family Contact)

Name:_____Relationship to patient:_____

Address: _____

City:_____State:_____Zip Code: _____

Email: _____

Telephone: (h)_____ (w)_____ (cell)_____

Who would you like to be your primary contact regarding your medical/mental health care and care coordination?_____

YOUR SOCIAL HISTORY:

Primary Language: _____

Marital Status: M❒ S❒ D❒ W❒ P❒ Handedness: Right❒ Left❒ Ambidextrous❒

Where do you live:_____Who do you live with:_____

Primary Occupation(s) Prior to Retiring:_____

PERSONAL AND FAMILY MEDICAL AND PSYCHIATRIC HISTORY:

ALLERGIES:

Are you allergic to any medication(s)? If yes, please list them.

_____

Do you have any other allergies? If yes, please list them.

_____

VACCINATIONS:

Influenza (Flu) Vaccination: Yes ❒ No ❒ Date Given: _____

Pneumococcal (Pneumonia) Vaccination: Yes ❒ No ❒ Date Given: _____

Zostavax (Shingles) Vaccination: Yes ❒ No ❒ Date Given: _____

Tetanus Vaccination: Yes ❒ No ❒ Date Given: _____

Preventative Screenings: (Tests and Dates)_____

ADVANCE CARE PLANNING:

Have you executed any of the following documents? Please bring the Integrated Memory Care Clinic copies of these documents if you have them.

Advance directives, Living Will*, or Power of Attorney for Healthcare: YES❒ NO❒

**A living will is a document that states your wishes regarding medical interventions near the end of your life. A living will is NOT your "Last Will & Testament." These documents are different.*

NEW SYMPTOMS OR HEALTH CONCERNS:

Are you having any new symptoms or current health concerns? _____

_____

When did the symptoms begin? _____

How did the symptoms begin? Gradually ❒ Suddenly ❒ Occasionally ❒

Has anything helped or worsened the symptoms? _____

PAST SURGICAL HISTORY:

Date of Surgery or Operation	**Type of Surgery or Operation**

PAST MEDICAL HISTORY OF PATIENT AND FAMILY:

Please check off all that apply for the patient and family:

	Patient	Mother	Father	Sibling	Other
Acid Reflux/GERD					
Alcohol or Substance Addiction/Misuse Patient: # of drinks/week: _____					
Allergies					
Anemia					
Anxiety					
Arthritis					
Asthma					
Bleeding Disorders					
Cancer (Type):					
Depression					
Diabetes					
Drug (Prescription or Street) Abuse					
Emphysema/Bronchitis/COPD					
Epilepsy/Seizure Disorder					
Headaches					
Hearing Loss					
Heart Disease					
High Blood Pressures					
High Cholesterol					
Irritable Bowel					
Kidney Disease					
Liver Disease					

Osteoporosis					
Smoking					
Stroke					
Thyroid Disease					
Chronic Pain					
Other Physical Diagnosis:					
Other Psychiatric Diagnosis:					

PHYSICIANS AND OTHER HEALTHCARE PROVIDERS:

We would like to know about other providers and specialists that have been involved in your medical care within the past three years.

Former Primary Care Provider: _____

Contact Information: _____

Current Medical/ Mental Health Specialists: Attach an additional sheet if necessary.

Physician/Practice Name	Specialty	Phone Number

PHARMACY AND MEDICATIONS:

Preferred Pharmacy:_____

Address and Phone Number: _____

The IMCC would like to know the current medications you are taking. If you bring all of your medications—including over-the-counter medications and supplements—to your clinic appointment, this section does not need to be completed. If you live at an assisted living community or a personal care home, please bring an official copy of their medication administration record to the appointment.

Please complete this section if you cannot bring your medications or facility medication list with you.

MEDICATION:	**DOSAGE/TIME TAKEN:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

A caregiver or family member should complete this section.

ACTIVITIES OF DAILY LIVING: **For each category, please ✓ the ONE option, which indicates the highest level of independent function most common for the patient.**	
FEEDING	
1. Eats without assistance	❒
2. Eats with minor assistance at meal times and, or with special preparation of food, or help in cleaning up after meals	❒
3. Feeds self with moderate assistance and is untidy	❒
4. Requires extensive assistance for all meals	❒
5. Does not feed self at all and resists efforts of others to feed him	❒
DRESSING	
1. Dresses, undresses, and selects clothes from own wardrobe	❒
2. Dresses and undresses self with minor assistance	❒
3. Needs moderate assistance in dressing or selection of clothes	❒
4. Needs major assistance in dressing, but cooperates with efforts of others to help	❒
5. Completely unable to dress self and resists efforts of others to help	❒
GROOMING	
1. Always neatly dressed, well-groomed, without assistance	❒
2. Grooms self adequately with occasional minor assistance, e.g., shaving	❒
3. Needs moderate and regular assistance or supervision in grooming	❒
4. Needs total grooming care, but can remain well-groomed after help from others	❒
5. Actively negates all efforts of others to maintain grooming	❒
WALKING (Physical Ambulation)	
1. Travels about grounds or city independently	❒
2. Walks within residence or about one block distance	❒
3. Walks with assistance of (✓) one ❒another person ❒railing ❒cane ❒walker ❒wheelchair ❒Gets in wheelchair without help ❒Needs help getting in and out of wheelchair	❒
4. Sits unsupported in chair or wheelchair but cannot propel self without help	❒
5. Bedridden more than half of the time	❒

ACTIVITIES OF DAILY LIVING:

For each category, please ✓ the ONE option, which indicates the highest level of independent function most common for the patient.

BATHING	
1. Bathes self (tub, shower, sponge bath) without help	❒
2. Bathes self with help in getting in and out of the tub	❒
3. Washes face and hands only, but cannot bath rest of body	❒
4. Does not wash self but is cooperative with those who bathe him	❒
5. Does not try to wash self and resists help to keep clean	❒
TOILETING	
1. Cares for self at toilet completely, no incontinence (accidents)	❒
2. Needs to be reminded/needs help in cleaning self; Has rare (weekly) accidents	❒
3. Soiling or wetting while asleep more than once a week	❒
4. Soiling or wetting while awake more than once a week	❒
5. No control of bowels or bladder	❒
ABILITY TO USE TELEPHONE	
1. Operates telephone on own initiative – looks up and dials numbers etc.	❒
2. Dials a few well-known numbers	❒
3. Answers telephone but does not dial	❒
4. Does not use telephone at all	❒
SHOPPING	
1. Takes care of all shopping needs independently	❒
2. Shops independently for small purchases	❒
3. Needs to be accompanied on any shopping trip	❒
4. Completely unable to shop	❒
FOOD PREPARATION	
1. Plans, prepares, and serves adequate meals independently	❒
2. Prepares adequate meals if supplied with ingredients	❒
3. Heats and serves prepared meals or prepares meals but does not maintain adequate diet	❒
4. Needs to have meals prepared and served	❒
HOUSEKEEPING	
1. Maintains house alone or with occasional assistance	❒
2. Performs light daily tasks such as dishwashing, bed making	❒
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness	❒
4. Needs help with all home maintenance tasks	❒
5. Does not participate in any housekeeping tasks	❒

ACTIVITIES OF DAILY LIVING:

For each category, please ✓ the ONE option, which indicates the highest level of independent function most common for the patient.

LAUNDRY	
1. Does personal laundry completely	❒
2. Launders small items, rinses socks, stockings, etc.	❒
3. All laundry must be done by others	❒
MODE OF TRANSPORTATION	
1. Travels independently on public transportation or drives own car	❒
2. Arranges own travel via taxi but doesn't use public transportation	❒
3. Travels on public transportation when assisted or accompanied by another person	❒
4. Travel limited to taxi or automobile with assistance of others	❒
5. Does not travel at all	❒
RESPONSIBLE FOR OWN MEDICATIONS	
1. Responsible for taking medication in correct dosages at correct times	❒
2. Takes responsibility if medication is prepared in advance in separate dosages	❒
3. Is not capable of dispensing own medication	❒
ABILITY TO HANDLE FINANCES	
1. Manages financial matters independently, budgets, writes checks, pays rent, bills, goes to bank, collects and keeps track of income	❒
2. Manages daily purchases but needs help with banking, major purchases, etc.	❒
3. Incapable of handling money	❒
DRIVING	
1. Drives alone safely	❒
2. Drives alone but has had one or more recent accidents	❒
3. Drives alone but has gotten lost	❒
4. Drives only with someone else in the car	❒
5. Never drove/no longer drives	❒
LIVING ARRANGEMENTS	
1. Lives alone	❒
2. Lives with spouse or family members	❒
3. Lives in assisted living	❒
4. Lives in a nursing home	❒

Neuropsychiatric Inventory Questionnaire Instructions

The following tool provides a reliable assessment of behaviors commonly observed in patients with dementia. **The Neuropsychiatric Inventory section, the next two pages, should be completed by a Family Member or Primary Care Giver.**

Please answer the following questions based on **CHANGES** that have occurred since the patient first began to experience **MEMORY PROBLEMS**.

Circle "**YES**" only if the symptom has been present in the past month. Otherwise, circle "**NO**".
For each item marked "YES"

- Rate the severity of the symptom (how it affects the patient):
  - 1=Mild (noticeable, but not a significant change)
  - 2=Moderate (significant, but not a dramatic change)
  - 3=Severe (very marked or prominent, a dramatic change)
- Rate the distress you experience because of that symptom (how it affects you):
  - 0=Not distressing at all
  - 1=Minimal (slightly distressing, not a problem to cope with)
  - 2=Mild (not very distressing, generally easy to cope with)
  - 3=Moderate (fairly distressing, not always easy to cope with)
  - 4=Severe (very distressing, difficult to cope with)
  - 5=Extreme or very severe (extremely distressing, unable to cope with)

Neuropsychiatric Inventory Questionnaire (See Instructions on Previous Page)

Delusions: Does the patient believe that others are stealing from him or her, or planning to harm him or her in some way? **Y N Severity: 1 2 3 Distress: 0 1 2 3 4 5**
Hallucinations: Does the patient act as if he or she hears voices? Does he or she talk to people **who** are not there? **Y N Severity: 1 2 3 Distress: 0 1 2 3 4 5**
Agitation or aggression: Is the patient stubborn and resistant to help from other? **Y N Severity: 1 2 3 Distress: 0 1 2 3 4 5**
Depression or dysphoria: Does the patient act as if he or she is sad or in low spirits? Does he or she cry? **Y N Severity: 1 2 3 Distress: 0 1 2 3 4 5**
Anxiety: Does the patient become upset when separated from you? Does he or she have any other signs of nervousness, such as shortness of breath, sighing, being unable to relax, or feeling excessively tense? **Y N Severity: 1 2 3 Distress: 0 1 2 3 4 5**
Elation or euphoria: Does the patient appear to feel too good or act excessively happy? **Y N Severity: 1 2 3 Distress: 0 1 2 3 4 5**
Apathy or indifference: Does the patient seem less interested in his or her usual activities and in the activities and plans of others? **Y N Severity: 1 2 3 Distress: 0 1 2 3 4 5**
Disinhibition: Does the patient seem to act impulsively? For example, does the patient talk to strangers as if he or she knows them, or does the patient say things that may hurt people's feelings? **Y N Severity: 1 2 3 Distress: 0 1 2 3 4 5**
Irritability or liability: Is the patient impatient and cranky? Does he or she have difficulty coping with delays or waiting for planned activities? **Y N Severity: 1 2 3 Distress: 0 1 2 3 4 5**
Motor disturbance: Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly? **Y N Severity: 1 2 3 Distress: 0 1 2 3 4 5**
Nighttime behaviors: Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day? **Y N Severity: 1 2 3 Distress: 0 1 2 3 4 5**
Appetite and eating: Has the patient lost or gained weight, or had a change in the food he or she likes? **Y N Severity: 1 2 3 Distress: 0 1 2 3 4 5**

Caregiver Stress Scale
To Be Completed by Caregiver

Caregiver Name: _____

Patient Name: _____

Caregiver Relationship to Patient:

❒ Spouse ❒ Father ❒ Son ❒ Same Sex Partner ❒ Friend

❒ Mother ❒ Daughter ❒ Sibling ❒ Significant Other ❒ Other _____

Caregiver Confidence

The caregiver…	Very Much	Somewhat	Just a Little	Not at All
Is confident how to deal with a very difficult situation				
Feels that he/she is a good caregiver				
Feels competent				
Feels self-confident				

Management of Situation

The caregiver…	Very Much	Somewhat	Just a Little	Not at All
Is firm in directing relative's behavior				
Does the things he/she has to do and let's other things slide				
Tries to find ways to keep relative busy				
Tries to learn as much as he/she can about the illness				