RUTGERS
Robert Wood Johnson Medical School
DIVISION OF COGNITIVE NEUROLOGY

COGNITIVE NEUROLOGY INTAKE QUESTIONNAIRE

(office use) Received on ___/___/___
Appt with _____ on ___/___/___

Basic information for Person with Memory or Thinking concerns

Are you ☐ filling out a form for yourself, or ☐ filling out the form for someone else

Name _____ Date of birth_____ Gender _____

Race & Ethnicity - Which of the following best describes the Person?

☐ Native Americans and Alaska Natives ☐ Black/African American ☐ Hispanic/Latinx American
☐ Native Hawaiians and Pacific Islanders ☐ South Asian/Asian American ☐ East Asian/Asian American
☐ White American ☐ Other _____

Languages spoken at home _____

Additional languages spoken as a child _____

Address _____ City _____ State ___ Zip _____

Home ☎(_____) _____ Cell ☎ ( ) _____ Email _____

Who lives with the Person? _____

Marital status ☐Single ☐Married ☐Divorced ☐Widowed Handedness _____

Employment status ☐Working ☐Unemployed ☐Retired Primary Occupation _____

Years of education _____ Highest degree(s) earned _____

What are the other ZIP codes where the Person has lived in his/her life? If you can't remember the ZIP code, report the cities/township/county/country

_____

Family Contact

Name _____ Relationship _____
Address _____ City _____ State ___ Zip _____
Home ☎(_____) _____ Cell ☎ ( ) _____ Email _____

Alternate family contact

Name _____ Relationship _____
Address _____ City _____ State ___ Zip _____
Home ☎(_____) _____ Cell ☎ ( ) _____ Email _____

Person filling out this form _____

Interest in Research

Are you interested in ***learning more about our research programs*** related to memory and thinking at Rutgers? Answering yes does not commit you to participating and does not influence your health care at Rutgers Health. ☐ Yes ☐ No

Is the Person with memory or thinking concerns an **Organ or Body Donor**? ☐ Yes ☐ No

HISTORY OF CHANGE IN THINKING, MEMORY, BEHAVIOR, AND LANGUAGE

What symptoms related to thinking and memory have you or others noticed?

☐ Forgetting recent events	☐ Difficulties speaking	☐ Hallucinations
☐ Forgetting conversations	☐ Difficulties coming up with words	☐ Slow movements
☐ Forgetting to pay bills	☐ Poor judgement or decision making	☐ Acting out dreams
☐ Missing appointments	☐ Excessive eating or pacing	☐ Daytime sleepiness
☐ Irritability	☐ Inappropriate behaviors in public	☐ Falls
☐ Sadness, crying, or loss of joy	☐ Anger bursts or cursing	☐ Anxiety
☐ Loss of interest in things	☐ Getting in trouble with the law	☐ Getting lost while out

What year did the first symptoms **begin**? _____

Did the symptoms **come on** ☐ Suddenly one day ☐ Over days or weeks ☐ Gradually

How have things **progressed**? ☐ Getting worse ☐ Staying the same ☐ Getting better

Has the person had the following test: ☐ Brain CT (CAT scan) ☐ Brain MRI
☐ Neuropsychological testing ☐ Spinal fluid test ☐ PET scan

Which physicians/psychologists has the Person seen for this? _____

If a brain CT/MRI/PET scan has been completed, **please carry the images on a CD with you** for us to review. We are often unable to get the information we need from the report.

MEDICAL HISTORY – has the Person been given any of the following diagnosis?

☐ Stroke/TIA	☐ ALS or Lou Gehrig's disease	☐ Depression
☐ Heart disease	☐ COVID-19 or coronavirus disease	☐ Bipolar disorder
☐ High blood pressure	☐ Celiac disease or gluten sensitivity	☐ Schizophrenia
☐ High cholesterol	☐ Multiple sclerosis	☐ PTSD/post-traumatic stress
☐ Diabetes	☐ Sleep apnea	☐ Chronic fatigue syndrome
☐ COPD	☐ Lupus or related disorder	☐ Fibromyalgia
☐ Concussion/head trauma	☐ Seizures or epilepsy	☐ Chronic migraine/headaches
☐ Currently having chemotherapy for cancer		☐ HIV

☐ Organ failure requiring organ transplantation (provide name of organ) _____

Is the Person a smoker? ☐ Never ☐ Quit 10 or more years ago
☐ Quit less than 10 years ago ☐ Yes, how many packs a day? ____

Does the person currently use marijuana (THC; excluding over-the-counter CBD)? ☐ Yes ☐ No

Alcohol use ☐ <1 drink a month ☐ 2-4 drinks per month ☐ 2-4 drinks per week
☐ 1-2 drinks per day ☐ more than 2 drinks a day
☐ Not regularly, but 4 or more drinks at a time when drinking

Is the Person driving? ☐Yes ☐No Is there any firearm in the residence? ☐Yes ☐No

Is the Person with thinking and memory concerns taking any of these medications regularly?

☐ Aspirin ☐ Coumadin/warfarin or like blood thinners (Eliquis, Xarelto)
☐ Other blood thinners (Plavix/clopidogrel, Brilinta/ticagrelor, Persantine/dipyridamole)
☐ Ritalin/Concerta (methylphenidate) or Provigil (modafinil) ☐ Pain/narcotic medications
☐ Benadryl ☐ Melatonin ☐ Herbal supplements
☐ Aricept/donepezil ☐ Exelon/rivastigmine ☐ Namenda/memantine
☐ Ativan/lorazepam ☐ Xanax/alprazolam ☐ Klonopin/clonazepam
☐ Abilify/aripiprazole ☐ Geodone/ziprasidone ☐ Latuda/lurasidone
☐ Nuplazid/pimavanserin ☐ Risperdal/risperidone ☐ Seroquel/quetiapine
☐ Zyprexa/olanzapine

FAMILY HISTORY

Has any family member had a diagnosis of dementia, Alzheimer's disease, frontotemporal dementia (FTD, also known as Pick's disease), Lewy body dementia, Parkinson's disease, ALS, or stroke? Please fill in information for siblings, cousins, grandparents, or aunts/uncles only if they have one of the disorders.

Family member	Dementia or Alzheimer's disease	FTD or Pick's disease	Lewy body dementia or Parkinson's disease	ALS or Lou Gehrig's disease	Stroke	Age when symptoms first begin
Mother						
Father						

DAILY ACTIVITIES

Is the Person able to perform the following now without help, and was he/she able to perform the same thing 2 years ago **without help**?

	Now	2 years ago
1. Dressing, including putting on shoes and socks	☐ yes ☐ no	☐ yes ☐ no
2. Walk across a room without cane or walker	☐ yes ☐ no	☐ yes ☐ no
3. Bathing or showering	☐ yes ☐ no	☐ yes ☐ no
4. Eating, such as cutting up your food	☐ yes ☐ no	☐ yes ☐ no
5. Getting in and out of bed	☐ yes ☐ no	☐ yes ☐ no
6. Using the toilet, including getting up and down	☐ yes ☐ no	☐ yes ☐ no
7. Using a map (not GPS) to figure out directions	☐ yes ☐ no	☐ yes ☐ no
8. Preparing a hot meal	☐ yes ☐ no	☐ yes ☐ no
9. Shopping for groceries (not online order)	☐ yes ☐ no	☐ yes ☐ no
10. Making phone calls	☐ yes ☐ no	☐ yes ☐ no
11. Managing and taking medications	☐ yes ☐ no	☐ yes ☐ no
12. Managing money, such as keeping track of expenses	☐ yes ☐ no	☐ yes ☐ no
13. Call a family member or 9-1-1 if something is wrong	☐ yes ☐ no	☐ yes ☐ no

Over the past year, have there been any of the following **life events**?

☐ Loss of spouse ☐ Moving/relocation ☐ Major hospitalization ☐ Major car accident

ADVACNED DIRECTIVES

Durable power of attorney for HEALTHCARE	☐ Yes	☐ No
Durable power of attorney for FINANCES	☐ Yes	☐ No
Living will*	☐ Yes	☐ No

* A living will is a document about how aggressive you wish to be about medical care near the end of life, not your "Last Will & Testament"

Anything else you'd like us to know?