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### Clinical Interview

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Interviewee: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Referral Source: \_\_\_\_\_

*Reason for Request from Referral Source (Questions to be Answered)*

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### HISTORY OF CURRENT CONCERNS

*Does the patient seem to have more difficulty than would be expected with the following...*

**Please Provide Details if you circle Yes, including approximately when each symptom began.**

Learning new things	Y or N	_____
Remembering things from past	Y or N	_____
Confusion	Y or N	_____
Disorientation	Y or N	_____
Finding words while talking	Y or N	_____
Wandering or getting lost	Y or N	_____
Automobile related accidents and/or Concerns	Y or N	_____
Accidentally starting fires	Y or N	_____
Planning	Y or N	_____
Organization	Y or N	_____
Personality changes	Y or N	_____
Repeating ideas or behaviors	Y or N	_____
Seemingly making things up	Y or N	_____
Delusions (unreal ideas)	Y or N	_____
Seeing, hearing, or feeling things which aren't there	Y or N	_____
Compulsive hoarding	Y or N	_____
Changes in sleep patterns	Y or N	_____
Changes in appetite	Y or N	_____
Other:		_____

Has the progression of the symptoms come on suddenly or slowly over time? \_\_\_\_\_

Are the symptoms present all of the time, are they worse during certain parts of the day, and/or do they come and go intermittently (i.e., good days and bad days)? \_\_\_\_\_

*Functional Skills*

Does the patient have difficulties in the following areas?

Dressing Self	Y or N	Does he/she receive help?	Y or N
Details: _____			
Bathing Self	Y or N	Does he/she receive help?	Y or N
Details: _____			
Driving	Y or N or N/A	Does he/she receive help?	Y or N
Details: _____			
Managing Finances	Y or N	Does he/she receive help?	Y or N
Details: _____			
Using Phone	Y or N	Does he/she receive help?	Y or N
Details: _____			
Cooking for Self	Y or N	Does he/she receive help?	Y or N
Details: _____			
Taking Medication	Y or N	Does he/she receive help?	Y or N
Details: _____			
Socialization	Y or N	Does he/she receive help?	Y or N
Details: _____			

Does the Patient have Durable Power of Attorney?

Whom?

When established?

- Healthcare \_\_\_\_\_
- Finances \_\_\_\_\_

*Medical History*

*If you circle Yes, please provide details*

Seizures	Y or N	_____
Closed Head Injury (Concussion)	Y or N	_____
Hospitalization	Y or N	_____
Surgery	Y or N	_____
Physical Impairment	Y or N	_____
Hearing Impairment	Y or N	_____
Visual Impairment	Y or N	_____
Macular Degeneration	Y or N	_____
Cataracts	Y or N	_____
Glaucoma	Y or N	_____
Heart Problem	Y or N	_____
Hypertension	Y or N	_____
Cancer	Y or N	_____
Strokes	Y or N	_____
Diabetes	Y or N	_____
Previous Neuroimaging	Y or N	_____
Urinary Tract Infections	Y or N	_____
Balance Problems	Y or N	_____
Fine Motor Skills	Y or N	_____

*Mental Health History*

*If you circle Yes, please provide details*

Depression	Y or N	_____
Nervousness	Y or N	_____
Racing Thoughts	Y or N	_____
Panic Attacks	Y or N	_____
Manic episodes	Y or N	_____
Delusions	Y or N	_____
Hallucinations	Y or N	_____
Suicidal ideation, plans, attempts	Y or N	_____
Homicidal ideation, plans, attempts	Y or N	_____

Does/did the patient use any of the following substances?

Substance	How much?	How often?	Since When?	Last Use?
Alcohol	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____

What mental health services has the patient received in the past or currently?

**If you circle Yes, please provide where services were received**

Counseling	Y or N	_____
Medication	Y or N	_____
Hospitalization	Y or N	_____

*Family of Origin History*

Where was the patient born? \_\_\_\_\_

History of Memory Problems in Family

\_\_\_\_\_

Frequency of Contact with Existing Family of Origin \_\_\_\_\_

\_\_\_\_\_

*Current Family and Social History*

Marital Status? \_\_\_\_\_ When married? \_\_\_\_\_ When widowed or divorced if applicable? \_\_\_\_\_

How Long at Current Residence? \_\_\_\_\_

Where was the previous residence and how long did the patient live there? \_\_\_\_\_

Children's Names, Locations, and Frequency of Contact? \_\_\_\_\_

\_\_\_\_\_

Describe the patient's relationships with family members currently \_\_\_\_\_

\_\_\_\_\_

What other important social supports did/does the patient have currently? \_\_\_\_\_

\_\_\_\_\_

*Education History*

Highest level of education? \_\_\_\_\_

What were/are the patient's average grades? \_\_\_\_\_

Military service? \_\_\_\_\_

*Employment History*

Is the patient presently employed? Laid off? Retired? On Disability? \_\_\_\_\_

If laid off, on disability, or retired, when did the patient last work? \_\_\_\_\_

Where is/was the patient employed? \_\_\_\_\_

How long? \_\_\_\_\_

Job title? \_\_\_\_\_

Please list other significant employment or volunteering activities \_\_\_\_\_

\_\_\_\_\_

Has the patient ever been disciplined or fired? Y or N

Explain: \_\_\_\_\_

Is the patient currently working in a capacity which meets her/his level of training?

Y or N or N/A \_\_\_\_\_