Center for Cognitive Health
10200 SW Eastridge St. Suite 105
Portland, OR 97225
503-207-2066
fax 503-548-4981

Thank you for your interest in seeking an evaluation at the Center for Cognitive Health. We are committed to providing you an extensive evaluation and treatment plan to maximize your, or your loved one's, cognitive health over the long term.
The enclosed packet needs to be completed and mailed back to our office prior to scheduling an appointment. For this evaluation to be complete we do request that you have a spouse, partner or family member fill out certain portions of this packet and take part in your in-person evaluation. Once we receive the completed packet you will get a phone call from a member of our staff.
Our Center is a fee-for-service clinic. The cost for our initial evaluation and treatment plan is $750. Returning clients are charged $500 per hour or $250 for half hour appointments. We do not take Medicare but we can bill your alternate insurance first and then send you a bill for any unpaid balance.
The work-up we may recommend could include formal Neuropsychological testing, as well as additional laboratory and brain imaging, all of which will be submitted to your Medicare or alternate insurance carrier for preauthorization coverage by our staff.
We are committed to providing you with superior multidisciplinary care that goes beyond just medication recommendations. Our Center provides education on risk factor reduction, life-style modification, and access to potential disease modifying treatment through clinical trials. If you are only interested in accessing clinical trials then there is no charge for screening visits.

Sincerely,

Michael S. Mega MD, PhD
Director, Center for Cognitive Health

1. Please **immediately** fill out the enclosed forms and send them back to us.

2. When we have received the enclosed forms – we will contact you to schedule an appointment with Dr. Michael Mega.

We look forward to meeting you. If you have any questions, please call us at 503-207-2066.

Center for Cognitive Health Questionnaire

Your Name: _________________________ Date form completed:_____________

<u>Please answer all the questions.</u> – if you are not the client then please answer questions based on the **client's** history and current abilities.

Client Name:____

Date of Birth:________________________

Address: ____

____

Zip Code: __________________

Telephone: ______________________________

Age:________ Handedness:______ Educational Level (years):_________ Gender:_______

Occupation:_________________________

Chief Complaint (how can the Clinic be helpful to you?)

____

____

<u>Informant/Caregiver</u>

Name: ____

Address: ____

____

Zip Code: __________________ Telephone: __________________

Relationship of the Client's Principle Caregiver:

___ Spouse ___Son ___ Daughter ___ Son-in-law ____ Daughter-in-law

___ Other Relative(s) ___Friend ___ Neighbor ___ Hired Caregiver

___ Other (specify:__________________________________)

Durable power of attorney ____Yes ____No ____Do not Know

Does the client have any problem with the following functions?

Learning and retaining new information
___ No ___ Yes ___ Don’t Know

For example: is more repetitive; has more trouble remembering recent conversations, events appointments; more frequently misplaces objects.

(Please circle answer below)
<6 months / 6 months - year / 1-2 years /+2 years

Comment:____

Handling complex tasks
___ No ___ Yes ___ Don’t Know

For example: has more trouble following a complex train of thought, performing tasks that require many steps such as balancing a checkbook or cooking a meal.

(Please circle answer below)
<6 months / 6 months - year / 1-2 years /+2 years

Comment: ____

Reasoning ability
___ No ___ Yes ___ Don’t Know

For example: is unable to respond with a reasonable plan to problems at work or home, such as knowing what to do if the bathroom floor flooded; shows uncharacteristic disregard for rules of social conduct.

(Please circle answer below)
<6 months / 6 months - year / 1-2 years /+2 years

Comment: ____

Spatial ability and orientation
___ No ___ Yes ___ Don’t Know

For example: has trouble driving, organizing objects around the house, finding his or her way around familiar places.

(Please circle answer below)
<6 months / 6 months - year / 1-2 years /+2 years

Comment: ____

Language
___ No ___ Yes ___ Don’t Know

For example: has increasing difficulty with finding the words to express what he or she wants to say and with following conversations.

(Please circle answer below)
<6 months / 6 months - year / 1-2 years /+2 years

Comment:____

Behavior
___ No ___ Yes ___ Don’t Know

For example: appears more passive and less responsive; is more irritable than usual; is more suspicious than usual; misinterprets visual or auditory stimuli.

(Please circle answer below)
<6 months / 6 months - year / 1-2 years /+2 years

Comment: ____

Note: Please have the client's significant other or care provider circle the best level of function

Memory

No memory loss or slight inconsistent forgetfulness.	0
Mild consistent forgetfulness; partial recollection of events; "benign" forgetfulness.	0.5
Moderate memory loss, more marked for recent events; defect interferes with everyday activities.	1
Severe memory loss; only highly learned material retained; new material rapidly lost.	2
Severe memory loss; only fragments remain.	3

Orientation

Fully oriented	0
Some difficulty with time relationships; oriented for place and person at examination but may have geographic disorientation	1
Usually disoriented in time, often to place	2
Orientation to person only	3

Judgment / Problem solving

Solves everyday problems well: judgment good in relation to past performance.	0
Only doubtful impairment in solving problems, similarities, differences.	0.5
Moderate difficulty in handling complex problems, social judgment usually maintained.	1
Severely impaired in handling problems, similarities, differences; social judgment usually impaired.	2
Unable to make judgments or solve problems.	3

Community affairs

Independent function at usual level in job, shopping, business and financial affairs, volunteer and social groups.	0
Only doubtful or mild impairment- if any, in these activities.	0.5
Unable to function independently at these activities though may still be engaged in some; may still appear normal to casual inspection.	1
No pretense of independent function outside home.	2

Home + hobbies

Life at home, hobbies, intellectual interests well maintained.	0
Life at home. hobbies, intellectual interests well maintained or only slightly impaired.	0.5
Mild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned.	1
Only simple chores preserved very restricted interests, poorly sustained.	2
No significant function in home outside of own room.	3

Personal care

Fully capable of self-care.	0
Needs occasional prompting.	1
Requires assistance in dressing, hygiene, keeping of personal effects.	2
Requires much help with personal care: often incontinent.	3

Past Medical History

			Medical/neurological illness
No	Yes	?	Hypertension
No	Yes	?	Cancer
No	Yes	?	Heart disease
No	Yes	?	Stroke
No	Yes	?	Seizure
No	Yes	?	Head trauma with loss of consciousness
No	Yes	?	If yes above were you hospitalized
No	Yes	?	Thyroid disease
No	Yes	?	Diabetes
No	Yes	?	Parkinson’s disease
No	Yes	?	Other medical illness

(specify)____

____

No	Yes	?	Other neurological disease

(specify)____

____

			Psychiatric illness
No	Yes	?	Depression
No	Yes	?	Alcoholism
No	Yes	?	Bipolar illness
No	Yes	?	Anxiety
No	Yes	?	Sleep disorder
No	Yes	?	Other psychiatric illness

(specify)____

____

			Surgeries
No	Yes	?	Coronary artery bypass
No	Yes	?	Hysterectomy/oophorectomy
No	Yes	?	Prostatectomy
No	Yes	?	Other

(specify all surgeries and dates below)

____

____

____

____

____

Family Medical History **(specify which by circling)**

No	Yes	?	Hypertension	**Mother**	**Father**	**Sibling**
No	Yes	?	Cancer	**Mother**	**Father**	**Sibling**
No	Yes	?	Heart disease	**Mother**	**Father**	**Sibling**
No	Yes	?	Stroke	**Mother**	**Father**	**Sibling**
No	Yes	?	Seizure	**Mother**	**Father**	**Sibling**
No	Yes	?	Diabetes	**Mother**	**Father**	**Sibling**
No	Yes	?	Parkinson's disease	**Mother**	**Father**	**Sibling**
No	Yes	?	Alzheimer's disease	**Mother**	**Father**	**Sibling**
No	Yes	?	Other neurological disease	**Mother**	**Father**	**Sibling**

(specify)____

____

Review of Systems: Check box if you have any problem in any of these organ systems and explain:

- ☐ Eyes ____
- ☐ Ears/Nose/Throat ____
- ☐ Heart and Blood Vessels ____
- ☐ Lungs ____
- ☐ Digestive system ____
- ☐ Genitals or Urinary system ____
- ☐ Muscles and Bones ____
- ☐ Skin ____
- ☐ Brain and Nerves ____
- ☐ Psychiatric ____
- ☐ Hormones ____
- ☐ Blood abnormalities ____
- ☐ Allergies and Immune system ____

Are you allergic to any medicines? No ☐ ☐ Yes – list them below.

____

Alcohol use: _____________ Tobacco use: _______________ Drug use: ______________________

Current Medication List

List all current medicine vitamins and herbal treatments.

Medication Name	Dosage/Frequency	Why do you take it?
Example: Aspirin	**325 mg tablet daily**	

Self-Care Tasks

	Totally Independent (no assist)	Receives or needs ANY Assistance	Frequency of Assistance (daily, weekly, monthly, etc)	Who Provides Assistance?	When did help start?
Example: Medication Management		***X***	***weekly***	***Daughter Joyce***	***6 months ago***
Meal Preparation					
Medication Management					
Money Management					
Telephoning					
Housekeeping					
Laundering					
Shopping					
Transportation					
Home Maintenance					
Reading					
Leisure Planning					
Walking					
Bathing					
Toilet Use					
Dressing					
Eating					
Transferring (getting up or down)					
Grooming					

Social History

Client's Name	
Birth city & state	
Year Immigrated to US, if born outside US:	
Mother's Name	
Age Died/cause Dementia Present (Yes/No)	
Father's Name	
Age Died/cause Dementia Present (Yes/No)	
Who reared client?	

Brothers & Sisters (age) Dementia Present (Yes/No)		Age Died	Death Cause
Other blood relatives with Dementia?			

Highest school grade completed

Spouses Names	Year Married	Year Divorced	Year Died

Military Service (Branch)		
Rank	Year Discharged	

Semi Retired	
Year Retired	
Previous occupations	
Did client retire because of current symptoms?	

Children - list in birth order	Age died

Hobbies/interests	
Clubs/Groups	

US States resided in	
Religious preference	
Ethnic/cultural affiliation	

Number of grandchildren	
Are they involved with client?	
Others important to client?	

Use this page for additional information if necessary: