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 ones', 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 bill insurance or accept Medicare. However, for those without the financial means to afford these, you can sign up on our website, www.centerforcognitivehealth.com, under the Free Screening tab to take part in free memory screen Mondays. We also offer the opportunity to participate in clinical trials (when available) which are also free of charge. For more information on whether you or loved one might benefit from a clinical trial, fill out the brief survey under the "Clinical Trials" tab on our website.

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:_____

Please answer all the questions. – 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?)

_____

_____

Informant/Caregiver

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 <u>significant other or care provider</u> 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

Military Service (Branch)

Rank

Year Discharged

Spouses Names	Year Married	Year Divorced	Year Died

Semi Retired

Year Retired

Previous occupations

Did client retire because of current symptoms?

Hobbies/interests

Clubs/Groups

Children - list in birth order	Age died

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: