MR# 0 | LAST NAME | FIRST NAME

VISIT DATE

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UF Memory and Cognitive Disorders Program - Caregiver/Informant Packet

Behavioral Assessment-(*to be completed by person other than patient*)

Person filling out form: ☐ Spouse ☐ Child ☐ Other _____

The following questions are based on changes that have occurred since the patient first began to experience memory problems. Indicate "yes" only if the symptom has been present in the past month; otherwise, indicate "no." Please answer each question honestly and carefully.

For each item marked "yes:"	
Rate the SEVERITY of the symptom (how it affects the patient): **Mild** (noticeable, but not a signficant change) **Moderate** (significant, but not a dramatic change) **Severe** (very marked or prominent; a dramatic change)	Rate the DISTRESS you experience because of the symptom (how it affects you): **Not Distressing** at all **Minimal** (slightly distressing, not a problem to cope with) **Mild** (not very distressing, generally easy to cope with) **Moderate** (fairly distressing, not always easy to cope with) **Severe** (very distressing, difficult to cope with) **Extreme** or very severe (extremely distressing, unable to cope with)

		Severity - for patient	**Distress** - to you the caregiver	
AGITATION OR AGGRESSION: Is the patient stubborn and resistive to help from others?	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	☐ Not distressing ☐ Minimal ☐ Mild	☐ Moderate ☐ Severe ☐ Extreme
HALLUCINATIONS: Does the patient act as if he or she hears voices? Does he or she talk to people who are not there?	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	☐ Not distressing ☐ Minimal ☐ Mild	☐ Moderate ☐ Severe ☐ Extreme
DELUSIONS: Does the patient believe that others are stealing from him or her, or planning to harm him or her in some way?	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	☐ Not distressing ☐ Minimal ☐ Mild	☐ Moderate ☐ Severe ☐ Extreme

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For each item marked "yes:"	
Rate the SEVERITY of the symptom (how it affects the patient): **Mild** (noticeable, but not a signficant change) **Moderate** (significant, but not a dramatic change) **Severe** (very marked or prominent; a dramatic change)	Rate the DISTRESS you experience because of the symptom (how it affects you): **Not Distressing** at all **Minimal** (slightly distressing, not a problem to cope with) **Mild** (not very distressing, generally easy to cope with) **Moderate** (fairly distressing, not always easy to cope with) **Severe** (very distressing, difficult to cope with) **Extreme** or very severe (extremely distressing, unable to cope with)

		Severity - for patient	**Distress -** to you the caregiver	
DEPRESSION OR DYSPHORIA: Does the patient act as if he or she is sad or in low spirits? Does he or she cry?	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	☐ Not distressing ☐ Minimal ☐ Mild	☐ Moderate ☐ Severe ☐ Extreme
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?	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	☐ Not distressing ☐ Minimal ☐ Mild	☐ Moderate ☐ Severe ☐ Extreme
ELATION OR EUPHORIA: Does the patient appear to feel too good or act excessively happy?	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	☐ Not distressing ☐ Minimal ☐ Mild	☐ Moderate ☐ Severe ☐ Extreme
APATHY OR INDIFFERENCE: Does the patient seem less interested in his or her usual activities and in the activities and plans of others?	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	☐ Not distressing ☐ Minimal ☐ Mild	☐ Moderate ☐ Severe ☐ Extreme

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For each item marked "yes:"	
Rate the SEVERITY of the symptom (how it affects the patient): **Mild** (noticeable, but not a signficant change) **Moderate** (significant, but not a dramatic change) **Severe** (very marked or prominent; a dramatic change)	Rate the DISTRESS you experience because of the symptom (how it affects you): **Not Distressing** at all **Minimal** (slightly distressing, not a problem to cope with) **Mild** (not very distressing, generally easy to cope with) **Moderate** (fairly distressing, not always easy to cope with) **Severe** (very distressing, difficult to cope with) **Extreme** or very severe (extremely distressing, unable to cope with)

		Severity - for patient	**Distress -** to you the caregiver	
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?	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	☐ Not distressing ☐ Minimal ☐ Mild	☐ Moderate ☐ Severe ☐ Extreme
IRRITABILITY OR LABILITY: Is the patient impatient or cranky? Does he or she have difficulty coping with delays or waiting for planned activities?	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	☐ Not distressing ☐ Minimal ☐ Mild	☐ Moderate ☐ Severe ☐ Extreme
MOTOR DISTURBANCE: Does the patient engage in repetitive activities, such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	☐ Not distressing ☐ Minimal ☐ Mild	☐ Moderate ☐ Severe ☐ Extreme
NIGHTTIME BEHAVIORS: Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	☐ Not distressing ☐ Minimal ☐ Mild	☐ Moderate ☐ Severe ☐ Extreme
APPETITE AND EATING: Has the patient lost or gained weight, or had a change in the food he or she likes?	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	☐ Not distressing ☐ Minimal ☐ Mild	☐ Moderate ☐ Severe ☐ Extreme

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Functional Assessment

SCALE: *(Indicate the level of difficulty for each activity.)*

0 Can do this without help.
1 Has some difficulty, but can do this without help.
2 Need help with this.
3 Can't do this.
4 Never did this.

In the past four weeks, did the patient have any difficulty or need help with:

	Score
1. Writing checks, paying bills, or balancing a checkbook.	
2. Assembling tax records, business affairs, or other papers.	
3. Shopping alone for clothes, household necessities, or groceries.	
4. Playing a game of skill, working on a hobby.	
5. Heating water, making a cup of coffee, turning off the stove.	
6. Preparing a balanced meal.	
7. Keeping track of current events.	
8. Following a TV show, book, or magazine and being able to discuss with acquaintances.	
9. Remembering appointments or remembering to take medications.	
10. Keeping track of recent conversations, recent events, and the date.	
11. Driving, traveling out of the neighborhood, or arranging to take public transportation.	
(Office Use Only) **Total (maximum score = 44)** **(did not complete = 88)**	