

NORMAL CONTROL SCREEN

PERSONAL DATA

Name:
Date Interviewed
Phone:
Age:
Date of birth: SS#
Referral Source:

EDUCATION

Highest level of education?
Trouble w/any subjects in school? (e.g. reading, spelling, math)
Present/past primary job?
?NART
Native English Speaker?

SYSTEMIC HEALTH

Last time saw physician?
Hospitalizations of any sort?
Indicate following conditions doctor said you have:

- 1.Heart condition
 attack w/loss of consciousness-amt. of time LOC
 weakness, dizziness?
- 2.High blood pressure
 well controlled?
 type of medication?
 last reading? (maximum numerator/denominator-160/90)
- 3.Anemia
 type?(watch e.g.pernicious, sickle cell)
- 4.Diabetes
 adult onset?
 diet/insulin controlled?
 history of coma?
- 5.Motor restrictions?-describe task
 (arthritis-move well enough w/o pain to do task?)
 (broken bones/amputation)
- 6.Sleeping problems?e.g.apnea
- 7.cancer
 type?(alcoholics prone to mouth, tongue, pharynx, esophagus)
 metastatic?
- 8.Hx serious or recurrent infections (e.g.meningitis, herpes)
- 9.Smoke?-amount
- 10.Other-particularly liver disease
 (watch indicators of alcohol abuse-e.g.cirrhosis, hepatitis)
 (any other debilitating-e.g.kidney failure)
- 11.Current medications-Reason for them-if not obvious
 watch:pain killers, sleeping pills, allergy pills, tranquilizers, blood thinner
 medications (e.g.coumadin), cold, antibiotics (infection?)
- 12.Recreational drug use? Do you or have you in the past taken drugs such as:
 amphetamines, barbituates, LSD, marijuana, cocaine (only ask if you're
 suspicious—older adults rarely endorse this)

NEURO/PSYCHIATRIC

1. Have you ever been hit on the head? Circumstance?
e.g. car accident, boxing, football (sports)
Without losing consciousness?
Lose consciousness?
how long?
what's the last thing you remember before and after?
memory problems/amnesia after? Any other symptoms?
2. What hand do you write with?
3. Have you ever sought counselling?
type? (psychiatric? -depression, schizophrenia)
drugs prescribed?
4. Ever seen a neurologist? Reason?
watch stroke, TIA's, seizures, Parkinson's, etc.
5. Symptoms/Cognitive—Have you ever felt:
dizziness, fainting spells, loss of memory, frequent or severe headaches,
numb/tingling in body
Had problems with: understanding what you've read, paying attention to what
people have said to you, doing simple arithmetic in your head—IS THIS NEW?

EYE HEALTH

1. How is your vision? Wear glasses?
2. Last time you saw an eye doctor?
3. Did you ever have any problems with your eyes
e.g. cataracts, glaucoma
4. Are you colorblind?

HEARING

1. Last time hearing tested?
2. Do you have difficulty?
3. Do you wear hearing aids?

NEURO/PSYCHIATRIC cont.

6. Alcohol—How much do you drink?
Present pattern of consumption?
#OF DRINKS/WEEK, TYPE(S) OF DRINK!!!
At any time in the past, was this pattern different? How so?
Duration, How long ago? Did this interfere with work?
Have you ever been treated for an alcohol problem?
(watch-blackouts, seizures, delirium tremens)
7. MINI-MENTAL STATE
8. DEPRESSION SCALE

IS THERE ANYTHING ELSE YOU MIGHT WANT TO ADD THAT WOULD BE IMPORTANT FOR US TO KNOW ABOUT YOU?

e.g. any handicap that limits your daily activities

COMMENTS? IMPRESSIONS?