INFORMANT REPORT

INSTRUCTIONS: This report is to be completed by the informant. The INFORMANT is defined as the person who gives information about/to another individual.

INFORMATION REGARDING: _____
(Patient's Name)

INFORMANT'S NAME: _____

1. **Your month/year of birth:** _____
2. **Your sex:** **__ Male** **__ Female**
3. **Are you of Hispanic/Latino ethnicity (i.e., having origins from a mainly Spanish-speaking Latin American Country), regardless of race?** **__ Yes** **__ No**
   - If YES, what are your reported origins?

   __ Mexican/Chicano/Mexican-American __ Puerto Rican
   __ Cuban __ Dominican __ Central American
   __ South American __ Other (specify) _____ __ Unknown
4. **What is your race? (Race is defined as a socially meaningful category of people who share biological traits that are obvious and considered important)**

   __ White __ Black/African American __ American Indian or Alaska Native
   __ Asian __ Native Hawaiian or Other Pacific Islander
   __ Other (specify) _____ __ Unknown
5. **Any additional reportable race?**

   __ White __ Black/African American __ American Indian or Alaska Native
   __ Asian __ Native Hawaiian or Other Pacific Islander
   __ Other (specify) _____ __ Unknown
6. **Years of education: How many years of school have you attended? (Include primary through any college attended)** _____
7. **Your relationship to the patient/subject?**

   __ Spouse/partner __ Child __ Sibling
   __ Other relative __ Friend/neighbor __ Paid caregiver/provider
   __ Other (specify) _____
8. **Do you live with the subject?** **__Yes** **__No**
   - If NO, approximate frequency of in-person visits:

   __ Daily __ At least 3x/week __ Weekly
   __ At least 3x/month __ Monthly __ Less than once a month
   - If NO, approximate frequency of telephone contact:

   __ Daily __ At least 3x/week __ Weekly
   __ At least 3x/month __ Monthly __ Less than once a month

PATIENT NAME:
DATE OF BIRTH:
DATE:
NAME OF PERSON COMPLETING QUESTIONNAIRE: (If other than patient. Please respond to questions on behalf of patient above.)
RELATIONSHIP TO PATIENT:
How often do you spend time with patient: Daily☐ Weekly☐ Monthly☐ Every 3 month☐ Every 6 month☐ Yearly☐

This questionnaire will assist the medical team in completing the patient's evaluation.
Please:

- Answer these questions honestly and to the best of your ability.
- Be specific. For example, "Last Tuesday, my loved one got lost on the way home from the store. It was scary."

In addition to the questions below the medical provider may also ask details about:

- Past and current medical problems and surgical history
- Family medical history
- The patient's social history
- All medications that the patient is currently taking including: prescription medications, over-the-counter vitamins, aspirin, etc. herbal supplements,
- Past or present use of: alcohol, marijuana (CBD/THC) or other social drugs such as stimulants, narcotics, or sedatives.

Question: (check all that apply)	YES	Please provide additional comments if necessary:
Does the patient have any problems with memory?		
Does the patient misplace items often (e.g., phone, keys)?		
Does the patient rely more on notes?		
Does the patient have trouble with recent memory (conversations, recent events) compared to remote memory?		
Does the patient ask repetitive questions?		
Does the patient have difficulty expressing words, difficulty understanding words or conversations?		
Does the patient have difficulty finding the word or name they want to use?		
Does the patient have difficulty understanding what people are saying to them?		
Does the patient have any difficulty pronouncing words that were easy for them to pronounce in the past?		

Question: (check all that apply)	YES	Please provide additional comments if necessary:
Does the patient have difficulty planning, starting, or finishing complicated tasks at home or at work?		
Does the patient have difficulty keeping their home or office as neat and organized/clean as it used to?		
Does the patient have problems finishing a task because they get distracted easily?		
Does the patient get lost while walking or driving?		
Does the patient have difficulty driving or walking to familiar places? i.e., grocery store, post office, friend's house, etc.		
Does the patient get lost in a familiar store or restaurant?		
Does the patient have difficulty seeing things properly or judging distances properly?		
Does the patient's motor vehicle show evidence of damage?		
Does the patient have difficulty figuring out how to position themselves to sit in a chair?		
Does the patient complain of difficulty seeing while reading?		
Does the patient complain that their eyes do not work?		
Does the patient have trouble seeing things that are right in front of them?		
Does the patient have difficulty recognizing people?		
Has the patient's mood changed?		
Does the patient cry a lot?		
Does the patient feel hopeless about life or about the future?		
Does the patient feel worthless or bad about themselves?		
Has the patient lost motivation or energy to do things they used to enjoy?		
Does the patient have decreased interest in social activities?		
Does the patient have decreased interest in church or community groups?		
Does the patient have decreased interest in hobbies?		
Does the patient become angry more easily?		

Question: (check all that apply)	YES	Please provide additional comments if necessary:
Does the patient get angry about things that would not have bothered them in the past?		
Sometimes we have patients who seem to forget how to behave in public. Has this been an issue for the patient?		
Has the patient done anything that may have been embarrassing to the family? e.g., calling people fat in public when they might hear?		
Has the patient ever told dirty jokes in inappropriate situations?		
Has the patient ever told personal things about themselves or family to strangers?		
Has the patient ever eaten from other people's plates at restaurants?		
Has the patient had any problems with beliefs that are unusual or not realistic?		
Does the patient feel like someone is out to get them?		
Does the patient feel like they might have special powers or special relationships with famous or powerful people?		
Has the patient been seeing or hearing anything that might not be there (or others can't see or hear)?		
Has the patient become fixated on certain ideas that they can't get out of their head or have developed any specific rituals?		
Does the patient have any obsessions with certain political or religious ideas?		
Does the patient have any obsessions about timing or routine being adhered to precisely?		
Does the patient have any obsessions with specific games, movies, or specific forms of entertainment?		
Does the patient have any changes in sleep?		
Does the patient wake up a lot in the middle of the night?		
Does the patient have problems falling asleep?		
Has the patient's partner reported that the patient may have problems acting out dreams (yelling, screaming, hitting)?		
Does the patient snore?		
Has the patient's partner ever reported that the patient may have breathing stoppages while they sleep?		
Is the patient sleepy during the day?		
Have there been changes in the patients eating habits?		
Has the patient been eating more or less than usual?		

Question: (check all that apply)	YES	Please provide additional comments if necessary:
Has the patient had any unintentional weight gain?		
Has the patient had any unintentional weight loss?		
Does the patient want to eat specific foods all the time?		
Does the patient want to eat sweets or carbohydrates more than they used to?		
Does the patient seem less concerned about others' needs, problems?		
Do you feel the patient does not react appropriately in an emergency or when someone needs help?		
Do you feel the patient does not react emotionally when someone has a particularly sad or happy event (e.g., a loss or major achievement)?		
Does the patient seem to be more open to scams or solicitations?		
Has the patient been buying lots of magazines or online offers?		
Has the patient ever been fooled by a suspicious business arrangement?		
Does the patient have involuntary shaking in their hands, arms, legs or chin?		
Does the patient's limbs feel rigid or stiff?		
Does the patient have problems turning their head and neck easily?		
Has the patient's movements been slowing down?		
Is the patient walking slower?		
Does it take the patient longer to button their shirt?		
Is the patient's handwriting smaller?		
Has the patient had changes in their ability to walk?		
Is the patient stooped over when walking?		
Does the patient drag their feet when they walk?		
Is the patient's steps shorter or do they get stuck when walking?		
Has the patient fallen down in the past couple of years?		
If yes, how many times has the patient fallen?		

Question: (check all that apply)	YES	Please provide additional comments if necessary:
What were the circumstances of the patient's falls? (tripping, weakness of legs, loss of consciousness, unsteadiness)		
Does the patient feel unsteady on their feet?		
Is the patient weaker on one side of their body than the other?		
Has the patient had a stroke?		
Does the patient have trouble using one hand?		
Does the patient limp or drag one foot?		
Does the patient have involuntary movement of your limbs, such as jerking or twitching?		
Has the patient had changes to their muscles?		
Has the patient lost muscle mass?		
Is the patient's muscles weaker?		
Has any of the patient's muscles become smaller?		
Does one of the patient's arms behave as if it does not belong to them?		
Has the patients arm unbuttoned their shirt or grabbed something without their awareness or control?		
Does the patient have slurring of their speech?		
Does the patient's speech sound as if they are drunk?		
Does the patient have trouble swallowing?		
Does the patient cough or choke when eating or drinking?		
Has the patient had any other difficulty swallowing liquids or solid foods?		
Are there any members of the patient's family with "mental health problems, dementia, Parkinson's or other neurological problems"? For example: Alzheimer's disease, Parkinson's, schizophrenia, bipolar, depression		

Please check the box if any of the following are true:	YES	Please provide additional comments if necessary:
Has the patient had any changes in their ability to manage basic activities of daily living due to changes in memory or thinking?		
The patient cannot bathe without assistance		
The patient cannot dress independently		
The patient cannot manage their bladder and bowels without accidents		
Has there been a change in the patient's ability to manage their household due to problems with memory or thinking?		
The patient cannot manage their own shopping		
The patient cannot pay their bills on time		
The patient cannot complete household chores or projects		
The patient has left the stove on		
The patient cannot follow recipes		
The patient does not drive		
The patient has trouble completing tasks at work		
The patient lost their job because of trouble completing tasks at work		
The patient cannot manage their medications		

Thank you for completing the cognitive complaints patient questionnaire. Your input is very valuable for a thorough evaluation. Please feel free to provide the patient's physician further information below if necessary.

Medical Record Number _____

GERIATRIC NEUROBEHAVIOR AND ALZHEIMER CENTER
RANCHO LOS AMIGOS REHABILITATION HOSPITAL

Health History Form

DATE: _____

NAME: _____ **AGE**: _____

OCCUPATION: _____ **EDUCATION:** _____

HANDEDNESS: RIGHT _____ LEFT _____

WHO REFERRED YOU TO OUR NEUROLOGY CLINIC?

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

CHIEF COMPLAINT: (Describe the reason you are being seen. If you experienced an injury, please describe how it happened):

PAST MEDICAL HISTORY: (Describe any medical problems you have had in the past or currently have, and the year they were diagnosed):

PAST SURGICAL HISTORY: (Please list all surgeries you have had in the past. List appropriate date, type of surgery, hospital name and doctor's name).

NAME: _____

ALLERGIES:

Are you allergic to any medications? Yes _____ No _____
If yes, please name

_____

_____

_____

SOCIAL HISTORY:

Do you smoke: Yes _____ No _____

If yes, how much? _____

Do you drink alcoholic beverages? Yes _____ No _____

If yes, how often? _____

Do you use “recreational” drugs? Yes _____ No _____

CURRENT MEDICATIONS:

NAME	DOSAGE (#MG)	DIRECTIONS (Frequency)

HAVE YOU HAD	DATE PERFORMED	LOCATION PERFORMED
X-Rays		
MRI		
CT Scan		
EMG		
Myelogram		
Bone Scan		

NAME OF PATIENT: _____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING AND DATES:

		Approx date			Approx date			Approx date
[ ]	Heart trouble	___/___/___	[ ]	Thyroid disease	___/___/___	[ ]	Blood clots	___/___/___
[ ]	High blood pressure	___/___/___	[ ]	Migraine	___/___/___	[ ]	Elevated cholesterol	___/___/___
[ ]	Asthma	___/___/___	[ ]	Hepatitis	___/___/___	[ ]	Ulcer	___/___/___
[ ]	Emphysema	___/___/___	[ ]	Liver Disease	___/___/___	[ ]	Colitis	___/___/___
[ ]	TB	___/___/___	[ ]	Gall stones	___/___/___	[ ]	Bone disease	___/___/___
[ ]	Pneumonia	___/___/___	[ ]	Kidney disease	___/___/___	[ ]	Back pain	___/___/___
[ ]	Pleurisy	___/___/___	[ ]	Kidney stones	___/___/___	[ ]	Neck pain	___/___/___
[ ]	Other lung disease	___/___/___	[ ]	Gout	___/___/___	[ ]	Eye problems	___/___/___
[ ]	Diabetes	___/___/___	[ ]	Arthritis	___/___/___	[ ]	Ear problems	___/___/___
[ ]	Blood transfusion	___/___/___	[ ]	Mental illness	___/___/___	[ ]	Venereal disease	___/___/___
[ ]	Cancer	___/___/___	[ ]	Tropical disease	___/___/___			

SYSTEM REVIEW

GENERAL

- [ ] Recent weight gain/ amount
- [ ] Recent weight loss/ amount
- [ ] Fatigue
- [ ] Weakness
- [ ] Fever

NERVOUS SYSTEM

- [ ] Headaches
- [ ] Dizziness
- [ ] Fainting
- [ ] Muscle spasms
- [ ] Loss of consciousness
- [ ] Sensitivity or pain of hands and/or feet
- [ ] Face numbness or tingling
- [ ] Muscle weakness
- [ ] Muscle tenderness
- [ ] Walking difficulty

EARS

- [ ] Ringing in ears
- [ ] Loss of hearing

EYES

- [ ] Pain
- [ ] Loss of Vision
- [ ] Double or blurred vision
- [ ] Dryness
- [ ] Feels like something in the eye
- [ ] Redness

MOUTH

- [ ] Sore tongue
- [ ] Bleeding gums
- [ ] Sore in mouth
- [ ] Loss of taste
- [ ] Dryness

THROAT

- [ ] Frequent sore throats
- [ ] Hoarseness
- [ ] Difficulty in swallowing

NECK

- [ ] Swollen glands
- [ ] Tender glands

HEART & LUNGS

- [ ] Pain in chest
- [ ] Irregular heart beat
- [ ] Sudden changes in heart beat
- [ ] Shortness of breath
- [ ] Difficulty in breathing at night
- [ ] Swollen legs or feet
- [ ] High blood pressure
- [ ] Heart murmurs
- [ ] Cough
- [ ] Coughing up blood
- [ ] Wheezing
- [ ] Night sweats

STOMACH & INTESTINES

- [ ] Nausea
- [ ] Vomiting of blood or coffee ground material
- [ ] Stomach pain relieved by food or milk
- [ ] Yellow Jaundice
- [ ] Increasing constipation
- [ ] Persistent diarrhea
- [ ] Blood in stools
- [ ] Black stools
- [ ] Heartburn

KIDNEY/URINE/BLADDER

- [ ] Difficult urination
- [ ] Pain or bumming on urination
- [ ] Blood in urine
- [ ] Cloudy "smoky" urine
- [ ] Pus in urine
- [ ] Discharge from penis/vagina
- [ ] Frequent urination
- [ ] Getting up at night to pass urine
- [ ] Vaginal dryness
- [ ] Rash/ulcers
- [ ] Sexual difficulties
- [ ] Prostate trouble

PSYCHOLOGY

- [ ] Sad/depressed
- [ ] Happy/anxious
- [ ] Repetitive behavior/habits

ENDOCRINE

- [ ] Excessive thirst/hunger
- [ ] Nipples discharge

SKIN

- [ ] Easy bruising/amount
- [ ] Redness
- [ ] Rash
- [ ] Hives
- [ ] Sun Sensitive
- [ ] Tightness
- [ ] Hair loss
- [ ] Nodules/bumps
- [ ] Color Changes of hand or feet from the cold

JOINTS/BONES

- [ ] Morning stiffness Lasting how long? ____Hrs ____Min
- [ ] Joint pain
- [ ] Joint swelling

BLOOD

- [ ] Anemia
- [ ] Bleeding tendency

NOSE

- [ ] Nosebleeds
- [ ] Loss of smell
- [ ] Dryness

WEIGHT

Has your weight increased, decreased or remained the same in the past 2 years?

[ ] Yes [ ] No

[ ] If no, _____

I have reviewed and confirmed all the information listed above on this page.

_____

Physician's name (Please Print)

_____

Physician's Signature

_____

Date

NAME: _____

FAMILY HISTORY

	If Living		If Deceased,	
	Age	Health (describe any major illness)	Age:	Cause
Mother				
Father				
Sisters				
Brothers				
Children				

Rancho Los Amigos National Rehabilitation Center – University of Southern California
7601 Imperial Hwy, HB1018, STE 7, Downey, CA 90242
PH: (562) 385-8130 • FAX: (562) 803-6900
WWW.Ranchomemoryclinic.org

**** I HEREBY AUTHORIZE:***

Hospital/Organization:			
Physician:			
Address:			
Phone Number:		Fax:	

**** TO RELEASE INFORMATION ON:***

Patient's Name:	
Date of Birth:	

**** FOR THE FOLLOWING MEDICAL RECORDS:***

PROGRESS OFFICE NOTES:	
LABS:	
MEDICATION LIST:	
NEUROPSYCH TEST:	
EEG:	
*MRI SCAN - CD DISK & REPORT	
*PET SCAN - CD DISK & REPORT	
*CT SCAN - CD DISK & REPORT	
OTHER:	

*** CD DISKS ARE REQUIRED.**

**** PLEASE MAIL/FAX TO:***

Veronica Mendez, Clinical Coordinator
Geriatric Neurobehavior and Alzheimers Center
Rancho Los Amigos National Rehabilitation Center
7601 Imperial Hwy. HB1018, STE 7
Downey, CA 90242

FAX: 562-803-6900
PHONE: 562-385-8130

SIGN HERE

Signature of Patient or Authorized Representative: _____

Date: _____

COVID-19 Questionnaire

1) Were you ever known to have tested positive for the COVID-19 virus?

☐ Yes ☐ No

2) Did you ever get sick from infection with the COVID-19 virus?

☐ Yes (go to question 3)
☐ No (skip to question 7)
☐ Not Sure (go to question 3)

3) If so, were you hospitalized for the illness?

☐Yes (go to question 4)

☐ No (skip to question 6)

4) If you were hospitalized, were you admitted to the intensive care unit (ICU)?

☐ Yes (go to question 5)
☐ No (skip to question 6)

5) If you were admitted to the ICU, were you placed on a respirator?

☐ Yes ☐ No

6) If you got sick, which of the following symptoms did you have?

☐Fever and/or Chills ☐ Headache ☐ Loss of Sense of Smell

☐ Cough ☐ Shortness of Breath ☐ Sore Throat

☐Confusion ☐ Sleepiness ☐Diagnosed with a stroke?

☐ Other, Specify _____

7) Have you been vaccinated against infection with COVID-19?

☐ Yes ☐ No

The Memory/Dementia Clinic is partially funded by support through the California Department of Public Health, Alzheimer's Disease Program

Assembly Bill 959 mandates the California Department of Public Health to collect information regarding patients' race/ethnicity and sexual orientation and gender identity in an effort to ensure that our state-funded California Alzheimer's Disease Centers (CADCs) are serving individuals who reflect the diverse population of California, and to address key health policy issues of health disparities and cultural/linguistic competency. All answers are confidential, and you can select the "refuse to state" option if you prefer not to provide this information.

Sexual Orientation/Gender Identity

5. Patient's Sex Assigned at Birth: (22-24)

a) Male .....1 ☐
b) Female .....2 ☐
c) Other (Specify:_____).....3 ☐
d) Refused to provide .....99 ☐
e) Unknown .....999 ☐

6. Patient's Current Gender Identity: (25-27)

a) Male .....1 ☐
b) Female .....2 ☐
c) Trans male.....3 ☐
d) Trans female .....4 ☐
e) Gender queer.....5 ☐
f) Non-binary .....6 ☐
g) Questioning.....7 ☐
h) Unsure .....8 ☐
i) Other (Specify:_____).....9 ☐
j) Refused to provide .....99 ☐
k) Unknown .....999 ☐

7. Sexual Orientation. Do you think of yourself as: (28-30)

a) Heterosexual or straight .....1 ☐

b) Gay .....2 ☐

c) Lesbian .....3 ☐

d) Bisexual .....4 ☐

e) Queer .....5 ☐

f) Questioning.....6 ☐

g) Unsure .....7 ☐

h) Other (Specify:_____) .....8 ☐

i) Refused to provide .....99 ☐

j) Unknown .....999 ☐

Race/Ethnicity

8A. Hispanic or Latino origin: Are you Hispanic or Latino (ethnic/national origins in any part of Latin America - Cuban, Dominican, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.)? (31-33)

a) YES **(GO TO Q.8.B)** .....1 ☐

b) NO **(GO TO Q.8.B)** .....2 ☐

c) Refused to state **(GO TO Q.8.B.)** .....99 ☐

d) Unknown (**GO TO Q.8.B)** .....999 ☐

8B. What is your race? (Individuals should choose 1 category of race and/or ethnicity). (34-36)

White .....1 ☐

Black/African American .....2 ☐

Asian:

Asian Indian .....3 ☐

Cambodian .....4 ☐

Chinese .....5 ☐

Filipino .....6 ☐

Japanese .....7 ☐

Hmong .....8 ☐

Korean .....9 ☐

Laotian .....10 ☐

Vietnamese .....11 ☐

Other Asian (Specify:_____) .....12 ☐

Pacific Islander:

Native Hawaiian .....13 ☐

Guamanian .....14 ☐

Samoan .....15 ☐

Other Pacific Islanders (Specify:_____) ..16 ☐

American Indian
[(including North, South and Central American Indian) or Alaska Native (including Aleut and Eskimo)] .....17 ☐

Other Race (Specify:_____).....18 ☐

Multiracial .....19 ☐

Refused to state .....99 ☐

Unknown .....999 ☐