



No-Cost Memory Screening, NOT Medical Care

We are offering memory screenings at no cost to you. The purpose of the Memory Screens is to determine if you are eligible for a clinical trial or if you may benefit from a more comprehensive evaluation or services. The assessments are NOT being performed for the purposes of diagnosis, treatment or other medical care. You should consult with your healthcare provider(s) for any and all patient care needs, including diagnosis, treatment and other medical care.

No written feedback will be provided, however recommendations will be discussed at the time of screening. Per your request, a summary of the test scores can be sent to your doctor's office.

We would like to add your information to our database so that we may contact you in the future, should you potentially qualify for a study. Please indicate below whether you grant The CRCNJ permission to do so.

\_\_\_\_\_ Yes    \_\_\_\_\_ No

I acknowledge the above statement and understand and agree.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian



**Patient Information and Questionnaire**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_(H) \_\_\_\_\_(C)

Email: \_\_\_\_\_

**Contact Name (if Different than Patient):** \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_(H) \_\_\_\_\_(C)

Email Address: \_\_\_\_\_

Is the contact a legal guardian or holder of POA/Health Proxy?  Yes  No *If yes, please provide documentation. \**

**The CRCNJ respects your right to confidential communication about your protected health information (PHI). As specified by you below, The CRCNJ will use the provided phone numbers and emails to leave messages about services and educational events.**

Yes  No

**Referring Physician or Source** (Name and Specialty), if applicable: \_\_\_\_\_

**Relevant History:**

What are you experiencing in your daily life that has caused you to seek a memory screening?

\_\_\_\_\_

When did these symptoms begin? \_\_\_\_\_ (approximate date)  Gradual Onset  Sudden Onset

Have the symptoms changed in the past month?  worse  better or  same

Have you recently been evaluated by a neurologist or psychiatrist or had any related testing?

\_\_\_\_\_

**Past Medical History:** Do you **have** any of the following medical conditions?

	YES	NO		YES	NO
Visual Loss			Fainting or blackouts		
Glaucoma			Seizures/epilepsy		
Loss of Hearing			Seizures with high fever as child or baby		
Recurrent Vertigo			Head trauma w/loss of consciousness		
High Blood Pressure			Hematological disorders (sickle cell, hemophilia)		
High Cholesterol			Bleeding tendency		
Heart disease (angina, heart arrhythmia)			Diabetes		
Lung disease (emphysema, COPD, asthma)			Thyroid condition		
Gastrointestinal disease/Incontinence			Immunologic disorders (rheumatoid arthritis, lupus)		
Liver disease			Chronic allergies/hay fever		
Chronic skin condition			Kidney disease or other urological disorders		
Arthritis			Infectious Diseases (Tuberculosis, HIV< Encephalitis)		
Chronic sleep disorders			Infections (Lyme)		
Stroke or TIA			Cancer		
Alzheimer's or other cognitive disorders					
Parkinson's or other movement disorders					
Frequent Falls/imbalance					
Tremor/shaking/involuntary movement					

**Additional Relevant History:** Please explain

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**Current Medications:**

Please list any medications you are currently taking including over the counter medications, supplements and vitamins.

Medication	Start Date	Reason for Medication	Strength (mg/ml)	Dosing (frequency per day)

Please check here if there are additional medications and a complete list was provided separately.



If not listed in above current medications, have you ever taken any of the following medications for cognitive symptoms?

Medication	Yes	No	If so, when?
Aricept® (donepezil)			
Exelon® (rivastigmine)			
Namenda® (memantine)			
Namzaric® (memantine and donepezil)			
Razadyne® (galantamine)			

Psychiatric History: Have you ever experienced or received treatment for?

	Yes	No		Yes	No	Describe
Depression						
Anxiety						
Agitation			Any Psychiatric Hospitalizations?			If yes, when?
Hallucinations			Currently seeing a Psychologist or Therapist?			If yes, who?
Delusions			Currently seeing a Psychiatrist?			If yes, who?

Neuropsychiatric Work-up: Please use the chart below to describe any current or pending assessments by a neurologist or psychiatrist or any related testing:

Type of Evaluation or Test	Physician or Facility	Date	Results	Provided to CRCNJ (Y/N)
Neurological Evaluation				
Neuropsychological Evaluation				
MRI				
CT				
Blood Work				
PET (FDG or Amyloid)				
EEG				

Family History:

Does anyone in your family (i.e., blood relative) have a history of neurological or psychiatric illness? Please use the chart below to list these relatives and their history.

Family Member/Relation	Illnesses	Age of Onset of Illness



**Social History:**

How many years of education did you complete? \_\_\_\_\_ Highest degree you obtained? \_\_\_\_\_

Are you retired?  Yes  No If Yes, for how many years? \_\_\_\_\_

If No, what is your current occupation? \_\_\_\_\_

For how long have you been at your current job? \_\_\_\_\_

Please describe your previous employment history: \_\_\_\_\_

What is your marital status?  Single  Married  Widow  Divorced

If married, for how many years? \_\_\_\_\_ If divorced or widowed, for how many years? \_\_\_\_\_

Do you have any children?  Yes  No If yes, how many? \_\_\_\_\_

Who do you live with? \_\_\_\_\_

Do you need assistance with daily activities (e.g. grooming, dressing, driving, finances)?  Yes  No

If yes, please explain \_\_\_\_\_

Do you have adequate help and support?  Yes.  No

Do you have a driver's license? \_\_\_\_\_ If so, which state? \_\_\_\_\_

How do you like to spend your leisure time? \_\_\_\_\_

Do you exercise regularly?  Yes.  No If so, how \_\_\_\_\_

**Alcohol/Drug Use:**

Do you smoke cigarettes?  Yes  No  In the past. If yes, how many per day? \_\_\_\_\_

If yes, for how long have you been smoking? \_\_\_\_\_

If in the past, how many per day? \_\_\_\_\_

If in the past, for how long? \_\_\_\_\_

Do you, or have you ever, used any illicit drugs?  Yes  No

If yes, please describe: \_\_\_\_\_

Do you consume alcohol?  Yes  No If yes, please describe daily or weekly use: \_\_\_\_\_

Have you ever participated in a clinical trial?  Yes  No If so, provide more info: \_\_\_\_\_

**Did the patient fill out this questionnaire?**  Yes  No

**If No, who completed this form:** \_\_\_\_\_



**Authorization Form for Protected Health Information (PHI)**

This form, when completed and signed by you, authorizes The Cognitive and Research Center of New Jersey, LLC ("The CRCNJ") to release Protected Health Information ("PHI") from your clinical record to the person you designate, and to obtain PHI from entities designated by you. **Please note, that, as per our standard practice, we will automatically send a copy of the neuropsychological reports to the referring physician.**

You have the right to revoke this authorization, in writing, at any time, by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Please complete the following:

I, \_\_\_\_\_ authorize The Cognitive and Research Center of

New Jersey, LLC to

- Release
- Obtain
- Discuss on an ongoing basis:

With the following individuals (please provide the name of the doctors or family members):

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- All Records
- Specific records only (provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.): \_\_\_\_\_

I am requesting The CRCNJ to release/obtain this information for the following reasons:

- At the request of the individual – (if you are a patient of The CRCNJ and you do not desire to state a specific purpose)
- Other purpose (please specify)

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This authorization shall remain in effect until:

- Expiration date \_\_\_\_\_
- Until further notice

I am aware of my right to confidential communications under psychologist -patient privilege. **I understand that my psychologist generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.**

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by designated recipients and may no longer be protected by the HIPAA Privacy Rule. If authorizing the use or disclosure of psychotherapy notes, I understand that such authorization cannot be required as a condition of treatment, payment, enrollment, or eligibility for benefits.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Legal Guardian\* (Relationship)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Legal Guardian\* (Relationship)

*\*If the authorization is signed by a personal representative of the patient, a description and documentation of such representative's authority to act for the patient must be provided.*