LAWRENCEVILLE NEUROLOGY CENTER, P.A.

Neurology • Neurophysiology • Neuromuscular • Epilepsy • Stroke

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*Date:*_____

Geriatric Depression Scale: Short Form

Choose the best answer for how you felt over the past week:

1. Are you basically satisfied with your life? ☐ Yes ☐ **No**
2. Have you dropped many of your activities and interests? ☐ **Yes** ☐ No
3. Do you feel that your life is empty? ☐ **Yes** ☐ No
4. Do you often get bored? ☐ **Yes** ☐ No
5. Are you in good spirits most of the time? ☐ Yes ☐ **No**
6. Are you afraid that something bad is going to happen to you? ☐ **Yes** ☐ No
7. Do you feel happy most of the time? ☐ Yes ☐ **No**
8. Do you often feel helpless? ☐ **Yes** ☐ No
9. Do you prefer to stay home, rather than going out and doing new things? ☐ **Yes** ☐ No
10. Do you feel you have more problems with memory than most? ☐ **Yes** ☐ No
11. Do you think it is wonderful to be alive now? ☐ Yes ☐ **No**
12. Do you feel worthless the way you are now? ☐ **Yes** ☐ No
13. Do you feel full of energy? ☐ Yes ☐ **No**
14. Do you feel that your situation is hopeless? ☐ **Yes** ☐ No
15. Do you think that most people are better off than you are? ☐ **Yes** ☐ No

Answers in bold indicate depression. Score 1 point for each bolded answer.

A score > 5 points is suggestive of depression.
A score ≥ 10 points is almost always indicative of depression.
A score > 5 points should warrant a follow-up comprehensive assessment.

Source: Try This, Leonore Kurlowicz, PhD, RN, CS, FAAN

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~ Board Certified in Neuromuscular Medicine, ≠ Board Certified in Electrodiagnostic Medicine, ♦Board Certified in Clinical Neurophysiology
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Functional Activities Questionnaire

Activity	**Score (0 to 3)** **0 = independent** **1 = mild difficulty** **2 = requires assistance** **3 = dependent**
1. Writing checks and maintaining other financial records	
2. Assembling tax or business records	
3. Shopping alone	
4. Playing a game of skill	
5. Making coffee or tea	
6. Preparing a balanced meal	
7. Keeping track of current events	
8. Attending to and understanding a television program, book, or magazine	
9. Remembering appointments, family occasions, and medications	
10. Traveling out of the neighborhood	
Sum scores (0 to 30) **Score >8 = functional impairment**	

Source: Pfeffer Ri, et al, J Gerontol © 1982, Gerontology Society of America

EMG/Nerve Conduction Studies

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Caregiver Self-Assessment Questionnaire

Caregivers are often so concerned with caring for their relative's needs that they lose sight of their own wellbeing. Please take just a moment to answer the following questions. Once you have answered the questions, turn the page to do a self-evaluation.

During the past week or so, I have…

1. Had trouble keeping my mind on what I was doing ☐ Yes ☐ No
2. Felt that I couldn't even leave my relative alone ☐ Yes ☐ No
3. Had difficulty making decisions ☐ Yes ☐ No
4. Felt completely overwhelmed ☐ Yes ☐ No
5. Felt useful and needy ☐ Yes ☐ No
6. Felt lonely ☐ Yes ☐ No
7. Been upset that my relative has changed so much from his/her former self . ☐ Yes ☐ No
8. Felt a loss of privacy or personal time ☐ Yes ☐ No
9. Been edgy or irritable ☐ Yes ☐ No
10. Had sleep disturbed because of caring for my relative ☐ Yes ☐ No
11. Had a crying spell(s) ☐ Yes ☐ No
12. Felt strained between work and family responsibilities ☐ Yes ☐ No
13. Had back pain ☐ Yes ☐ No
14. Felt ill (*headaches, stomach problems, or common cold)* ☐ Yes ☐ No
15. Been satisfies with the support my family has given me ☐ Yes ☐ No
16. Found my relative's living situation to be inconvenient or a barrier to care ☐ Yes ☐ No
17. On a scale of 1 to 10 with 1 being "not stressful" to 10 being "extremely stressful," please rate your current level of stress. _____
18. On a scale of 1 to 10, with 1 being "very healthy" to 10 being "very ill," please rate your current health compared to what it was this time last year. _____

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Self- evaluation:

To determine the Score:

1. Reverse score questions 5 – 15. *(For example , a "No" response should be counted as a "Yes' and a "Yes response should be counted as a "No")*
2. Total the number of "Yes" responses.

To interpret the score:

Chances are that you are experiencing a high degree of distress:

- If you answered "Yes" to either or both Questions 4 and 11; or
- If your total "Yes" score = 10 or more; or
- If your score on Question 17 is 6 or higher; or
- If your score on Question 18 is 6 or higher.

Next steps:

- Consider seeing a doctor for a check-up for yourself
- Consider having some relief from caregiving. (Discuss with the doctor or social worker the resources available in your community.)
- Consider joining a support group.

Valuable Resources for Caregivers:

Eldercare Locator
(a national directory of community services)
1-800-677-1116
www.aoa.gov/elderpage/lcator/html

Family Caregiver Alliance
1-415-434-3388
www.caregiver.org

Medicaid Hotline
Baltimore, MD
1-800-638-6833

National Alliance for Caregiving
1-301-718-8444
www.caregiving.org

National Family Caregivers Association
1-800-896-3650
www.nfcacares.org

National Information Center for Children and Youth with Disabilities
1-800-695-0285
www.nichcy.org

Source: American Medical Association

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Neuropsychiatric Inventory Questionnaire

Name of patient: _____ Date: _____

Informant: Spouse: _____ Child: _____Other: _____

Please answer the following questions based on *changes* that have occurred since the patient first began to experience memory problems. Circle "yes" only if the symptom has been present in the past month. Otherwise, circle "no".

For each item marked "yes":
Rate the severity of the symptom (hoe it affects the patient):
1 = Mild (noticeable, but not a significant change)
2 = Moderate (significant, but not a dramatic change)
3 = Severe (very marked or prominent; a dramatic change)

Rate the *distress* you experience because of that symptom (how it affects you):
0 = Not distressing at all
1 = Minimal (slightly distressing, not a problem to cope with)
2 = Mild (not very distressing, generally easy to cope with)
3 = Moderate (fairly distressing, not always easy to cope with)
4 = Severe (very distressing, difficult to cope with)
5 = Extreme or very severe (extremely distressing, unable to cope with)

Please answer each question honestly and carefully. Ask for assistance if you are not sure how to answer any question.

Delusions ☐ Yes ☐ No	Does the patient believe that others are stealing from him or her, or planning to harm him or her in some way? Severity: 1 2 3 Distress: 1 2 3 4 5
Hallucinations ☐ Yes ☐ No	Does the patient act as if he or she hears voices? Does he or she talk to people who are not there? Severity: 1 2 3 Distress: 1 2 3 4 5
Agitation or aggression ☐ Yes ☐ No	Is the patient stubborn or resistive to help from others? Severity: 1 2 3 Distress: 1 2 3 4 5
Depression or dysphoria ☐ Yes ☐ No	Does the patient act as if he or she is sad or in low spirits? Does he or she cry? Severity: 1 2 3 Distress: 1 2 3 4 5
Anxiety ☐ Yes ☐ No	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? Severity: 1 2 3 Distress: 1 2 3 4 5
Elation or euphoria ☐ Yes ☐ No	Does the patient appear to feel too good, or act excessively happy? Severity: 1 2 3 Distress: 1 2 3 4 5
Apathy or indifference ☐ Yes ☐ No	Does the patient seem less interested in his or her usual activities and in the activities and plans of others? Severity: 1 2 3 Distress: 1 2 3 4 5
Disinhibition ☐ Yes ☐ No	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 peoples' feelings? Severity: 1 2 3 Distress: 1 2 3 4 5
Irritability or lability ☐ Yes ☐ No	Is the patient inpatient and cranky? Does he or she have difficulty coping with delays or waiting for planned activities? Severity: 1 2 3 Distress: 1 2 3 4 5
Motor disturbance ☐ Yes ☐ No	Does the patient engage in repetitive activities, such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly? Severity: 1 2 3 Distress: 1 2 3 4 5
Nighttime behavior ☐ Yes ☐ No	Does the patient awaken during the night, rise too early in the morning, or take excessive naps during the day?
Appetite and eating ☐ Yes ☐ No	Has the patient lost or gained weight, or had a change in the food he or she likes? Severity: 1 2 3 Distress: 1 2 3 4 5

Source: Kaufer 01, Cummings JL, Ketchel P,Smith \I, MacMillan A, Shelley T, et al. Validation of the NPI-Q, a brief clinical form of the Neuropsychiatric Inventory J NeuropsychiatryCiin Neurosci 2000; 12:233-9.