



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

F.A.A.N. - Fellow of American Academy of Neurology, \* Board Certified in Neurology, + Board Certified in Vascular Neurology  
~ 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) <b>Score &gt;8 = functional impairment</b>	

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



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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 .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 2. Felt that I couldn’t even leave my relative alone .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 3. Had difficulty making decisions .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 4. Felt completely overwhelmed .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 5. Felt useful and needy .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 6. Felt lonely .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 7. Been upset that my relative has changed so much from his/her former self .....   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 8. Felt a loss of privacy or personal time .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 9. Been edgy or irritable .....   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 10. Had sleep disturbed because of caring for my relative .....   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 11. Had a crying spell(s) .....   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 12. Felt strained between work and family responsibilities .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 13. Had back pain .....   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 14. Felt ill ( <i>headaches, stomach problems, or common cold</i> ) .....   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 15. Been satisfied with the support my family has given me .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 16. Found my relative’s living situation to be inconvenient or a barrier to care .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | 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](http://www.aoa.gov/elderpage/lcator/html)

#### Family Caregiver Alliance

1-415-434-3388

[www.caregiver.org](http://www.caregiver.org)

#### Medicaid Hotline

Baltimore, MD

1-800-638-6833

#### National Alliance for Caregiving

1-301-718-8444

[www.caregiving.org](http://www.caregiving.org)

#### National Family Caregivers Association

1-800-896-3650

[www.nfcacares.org](http://www.nfcacares.org)

#### National Information Center for Children and Youth with Disabilities

1-800-695-0285

[www.nichcy.org](http://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 (how 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient stubborn or resistive to help from others? Severity: 1 2 3 Distress: 1 2 3 4 5
Depression or dysphoria <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient impatient 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient awaken during the night, rise too early in the morning, or take excessive naps during the day?
Appetite and eating <input type="checkbox"/> Yes <input type="checkbox"/> 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