GERIATRIC ASSESSMENT COLLATERAL SOURCE QUESTIONNAIRE

This should be completed by the person(s) most familiar with the person being assessed. Please check appropriate responses to questions and provide additional information as directed. Your responses will not be shared with the patient. Please return the completed questionnaire in the enclosed post paid envelope. COMPLETE BOTH SIDES OF EACH PAGE.

1. COGNITION (Memory loss, confusion, disorientation)

1. Have you noticed signs of cognitive problems in your loved-one?
   ___Yes  ___No

(If you answered “No” to the above question, go on to Question #6)

2. In what year did you FIRST notice these cognitive problems? ____________

3. How did these cognitive problems seem to begin?
   ___Gradually  ___Suddenly  ___Do not know

4. Have these cognitive problems gotten worse since they first began?
   ___Yes  ___No  ___Do not know

If the problems have gotten worse, has the pattern of decline been marked by: (Check all that apply)
   ___Gradual and steady decline
   ___Sudden “step-downs”
   ___Do not know

5. Has your loved-one ever suffered symptoms of delirium? (brief periods of extreme confusion or disorientation, often due to illness, medication side-effects or being in the hospital)
   ___Yes  ___No  ___Do not know

If you answered “Yes”, please state the approximate year(s) and describe the event(s):

__________________________________________________________________________
Please answer each of the following questions. They describe possible symptoms caused by cognitive (thinking and memory) problems and whether you have noticed a change in the patient in the last several years. For each question, mark an “X” in one of the following columns: Yes (A change), No (No Change), or N/A (Don’t know).

<table>
<thead>
<tr>
<th>Remember, &quot;Yes, a change&quot; indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.</th>
<th>YES, A change</th>
<th>NO, No change</th>
<th>N/A, Don’t know</th>
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<tbody>
<tr>
<td>1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)</td>
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<td>2. Less interest in hobbies/activities</td>
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<td>3. Repeats the same things over and over (questions, stories, or statements)</td>
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<td>4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)</td>
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<td>5. Forgets correct month or year</td>
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<td>6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)</td>
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<td>7. Trouble remembering appointments</td>
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<td>8. Daily problems with thinking and/or memory</td>
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**TOTAL AD8 SCORE**

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005;65:559-564

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6. Has your loved-one driven a motor vehicle within the last 6 months?  ___Yes  ___No
   If he/she drives, are you concerned about his/her safety?  ___Yes  ___No

If you answered “Yes”, please circle any of the following areas of concern:

- Drives too fast  Gets angry or flustered  Straddles lanes
- Drives too slowly  Turns in front of other cars  Runs over curbs
- Strikes objects in garage or parking lots  Gets lost  Doesn’t pay attention

Other ____________________________

7. Does your loved-one currently:

- Pay monthly bills without help?  ___Yes  ___No
- Manage major finances without help?  ___Yes  ___No
- Carry a checkbook or credit/debit card(s)?  ___Yes  ___No

If you answered “Yes” to any of the above, are you concerned about his/her ability to safely do so?  ___Yes  ___No

If you answered “Yes”, please circle any of the following areas of concern:

- Forgets to pay routine monthly bills  Forgets to pay taxes, insurance premiums, etc.
- Pays the same bill twice  Overspends/over buys  Loses/misplaces important papers
- Gets frequent phone or mail solicitations  Enters many contests  Excessive casino gambling
- Has been financially victimized by:  A salesperson or solicitor  A family member or friend

Other ____________________________
II. Personality and Behaviors

8. Please circle any of the following words that describe your loved-one's **life-long personality traits**:

**Temperament:**
- Even-tempered
- Quick-tempered
- Happy-go-lucky

**Mood:**
- Depressed
- Worrier
- Nervous

**Outlook on life:**
- Optimistic
- Pessimistic
- Realistic

**Other:**
- Generous/Caring
- Socially-outgoing
- Homebody
- Stubborn
- Suspicious/mistrustful
- Held grudges
- Manipulative
- Impulsive
- Good sense of humor
- Dependent
- Adaptable
- Assertive
- Poor self-esteem
- Well-organized
- Hypochondriac
- Creative
- Self-confident
- Unmotivated
- Independent
- Practical

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**NPI-Q**

On the following page, please answer questions based on changes that may have occurred since your loved-one began to experience memory problems. Check **"YES" only** if the symptoms described have been present **IN THE PAST 1 MONTH**. Otherwise, check **"NO"**. Please answer **each** question carefully.

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 due to 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.
### NPI-O Distress Severity

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<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

- Has the patient lost or gained weight or had a change in the type of food he/she likes?
- The patient lose or gain weight during the day?
- Does the patient awaken you during the night or fall asleep too early in the morning or take excessive naps during the day?
- Does the patient engage in repetitive activities such as pacing around or touching things?

### NPI-O People's Feelings

- Is the patient irritable and cantankerous?
- Do they have difficulty coping with delays or waiting for planned activities?
- Do people seem to act impulsively, for example, taking to strangers as if he/she knows them or saying things that may hurt?

### NPI-O Activities or Plans of Others

- Does the patient seem less interested in his/her usual activities, or in others?
- Does the patient appear to feel too good or act excessively happy?

### NPI-O Mood

- Does the patient become upset when separated from you?
- Does the patient seem sad or say that he/she is depressed?

### NPI-O Perceptions

- Is the patient resistant to help from others at times or hard to handle?
- Does the patient seem to hear or see things that are not present?
- Does the patient have hallucinations, such as false visions or voices?

- Does the patient have false beliefs, such as thinking that others are stealing from him/her?
9. Please check “Yes” or “No” for each of the following questions about your loved-one’s current behaviors.

Is your loved-one ever physically abusive or threatening to you or anyone else?

____YES   ____NO

Does your loved-one exhibit any inappropriate sexual behaviors, such as excessive demands for, or discussion of sex or inappropriate behaviors?

____YES   ____NO

Does your loved-one want to die or threaten to harm himself/herself?

____YES   ____NO

10. In the past, has your loved-one ever suffered from mood or psychiatric problems (i.e. depression, anxiety, imagining untrue thoughts, seeing or hearing things that are not there, etc.)?

____ Yes  ______ No  ______ Do Not Know

If you answered “Yes”, please state the approximate year(s) and describe the event(s):

____________________________________________________________________________________

____________________________________________________________________________________

ADDITIONAL COMMENTS:

____________________________________________________________________________________

____________________________________________________________________________________

Name of the person completing this form ___________________________ Date ___________________________

Relationship to the patient ___________________________

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GERIATRIC ASSESSMENT COLLATERAL SOURCE QUESTIONNAIRE
AS THE PRIMARY SUPPORT PERSON FOR THE PATIENT, PLEASE ANSWER THE QUESTIONS BELOW AND MAKE CHECK MARKS AS APPROPRIATE.

Your Name _______________________________ Age __________

Your Relationship to the Patient ________________________________

Your Gender
___ Female  ___ Male

Your Marital Status
___Married  ___ Widowed
___Single  ___ Divorced/Separated

Your Employment Status
___ Employed full time  ___ Employed Part-time
___ Retired  ___ Not currently employed

Has your work status changed as a direct result of the care you provide for the patient?
___ Yes  ___ No

Do you live with the patient?
___ Yes  ___ No

If you do not live with the patient, how often do you VISIT him/her?
___ Daily  ___ Several times per week  ___ Once per week
___ At least once per month  ___ Less than once per month

If you do not live with the patient, how often do you SPEAK BY PHONE with him/her?
___ Daily  ___ Several times per week  ___ Once per week
___ At least once per month  ___ Less than once per month

Please answer questions on the back of this page
Please CHECK any of the following tasks with which YOU AND OTHER FAMILY MEMBERS assist the patient. Specify the name of the person(s) who perform each task.

<table>
<thead>
<tr>
<th>TASK</th>
<th>WHO HELPS WITH THIS?</th>
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<tbody>
<tr>
<td>Set up medications</td>
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<tr>
<td>Administer medications</td>
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<tr>
<td>Bathing</td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
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<td>Help to walk, or transfer</td>
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<td>Into or out of a bed or chair</td>
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<td>Toileting</td>
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<td>Meal preparation</td>
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<td>Feeding</td>
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<td>Housekeeping</td>
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<td>Laundry</td>
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<td>Transportation</td>
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<td>Shopping/errands</td>
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<td>Yard work/snow removal</td>
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<td>Help or oversight with finances</td>
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</table>

Approximately how many hours PER WEEK do you (and other family members) spend assisting the patient? __________________________

Overall, how stressed do you feel in providing assistance to the patient?

<table>
<thead>
<tr>
<th>Stress Level</th>
<th>Number</th>
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<tbody>
<tr>
<td>I feel no stress</td>
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<tr>
<td>I often feel stressed</td>
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<tr>
<td>I sometimes feel stressed</td>
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<tr>
<td>I always feel stressed</td>
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