OPAL Institute, Oregon Passionate Aging and Living
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BACKGROUND INFORMATION FORM

Name: _____ Age: _____ DOB: _____ Date: _____

Who is completing this form? SELF -- OTHER (Who: _____)

Your Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Email: _____

Who referred you to this clinic? _____ Why? _____

Type of Residence: _____ How long lived there: _____ Ethnicity: _____

Place of birth: _____ # Brothers _____# Sisters: _____ → # Deceased_____

Years of Education: _____ Lifetime Occupation_____ Date Retired: _____

Military Service: Branch _____Year Enlisted: _____ Year Discharged: _____ Saw Combat? Y/N

Marital Status: _____ Significant other's name _____ Do you live with your significant other?_____

Relationship History
1st Marriage/Partnership Name/Year_____ Divorce/Separate/Deceased Year _____
2nd Marriage/Partnership Name/Year_____ Divorce/Separate/Deceased Year _____
3rd Marriage/Partnership Name/Year_____ Divorce/Separate/Deceased Year _____

Significant other's health status: POOR FAIR GOOD DECEASED

Significant other's residence (if different) _____

Children (Name, age, city of residence): _____

_____

# of Grandchildren _____ # Great-Grandchildren _____ Guardian/Other:_____

Other significant people: _____

Please list all doctors, therapists, or other providers treating you right now:

_____

Medications: (Attach additional sheet if necessary)
__NAME_____DOSAGE_____START DATE_____
_____
_____

Please circle if you have experienced any:

neurological disease	head trauma	motor vehicle accidents	stroke
high blood pressure	high cholesterol	heart disease	seizure/epilepsy
Parkinson's Disease	diabetes	arthritis	lung disease sleeping
disorder	cancer	thyroid disease	chronic pain
childhood learning problem		urinary incontinence	problems walking

Other Health Conditions:

(Attach additional sheet if necessary)

__NAME_____DATE DIAGNOSED_____

_____

_____

_____

_____

Have you had an EEG, CT scan, MRI of the brain? (if yes, Date and Result, if known)

_____

History of depression, anxiety, or other mental health problems:

Mental Health Diagnoses _____ Hospitalizations & Date _____

Medications _____ Counseling (provider, start/end dates) _____

Have you ever thought about hurting or killing yourself? _____ If so, date of most recent _____
Have you ever made an attempt to hurt or kill yourself? _____ If so, date(s) _____

Who in your family has psychiatric problems, and what are they? _____

Who in your biological family has had dementia or memory problems? _____

Do you use tobacco? Circle: PAST --PRESENT—NEVER Start date: _____ Quit date: _____
If so, how much per day?

Are you exposed to second hand smoke in your home? Circle: PAST --PRESENT-- NEVER

Do you use alcohol? Circle: PAST --PRESENT-- NEVER
If so, how much per day?

Do you use "recreational drugs"? (i.e., marijuana, cocaine, meth) Circle: PAST --PRESENT-- NEVER

Have you ever been treated or arrested for using any kind of substance in the past?
If so, when and for what?

Do you use caffeine, coffee, tea, soda? Circle: PAST --PRESENT-- NEVER
If so, how much per day?

Are you sexually active? Circle types of partners: MALES--FEMALES--BOTH
Last approximate date of sexual activity with a partner:

Have you ever been abused? PHYSICALLY -- MENTALLY-- SEXUALLY --NEVER
If so, who was the abuser?

Are you currently driving? _____ When was your last ticket? _____When was your last accident? ____

If you are not driving, when did you quit and why? _____

Are guns or other weapons kept in your home? _____ Do you have access to them? _____

How would you describe your typical night's sleep this past month?_____

How would you describe your appetite this past month? _____

Describe your current exercise routine:_____

Are you currently engaged in any legal proceedings?(if yes, describe): _____

What do you do for fun? _____

Current support network: _____

Do you talk to someone on a regular basis? _____ If so, who and when did you last talk? _____

How often do you talk to this person in one week? _____

What pets do you have? _____

Do you practice any form of religion or spirituality? _____ If yes, what/how? _____

Are you satisfied with this spiritual involvement? _____

Circle below if you're having problems with:

bathing -- walking -- toileting -- eating -- dressing -- grooming -- using the telephone -- cooking shopping -- cleaning house -- laundry -- driving -- money management -- medication management
weight management -- safety judgment -- social judgment -- confusion -- odd behaviors -- outbursts
carrying on conversations -- hallucinations -- agitation -- paranoia -- violence

What is your <u>main</u> problem right now? Please provide any other information you think would be helpful in understanding your condition.

_____

_____

_____

Any Memory Changes?

□ Forgets recent events, appointments

□ Forgets names of relatives or close friends

□ Memory problem affects work, social activities, taking care of things around the house (like paying bills, shopping, laundry, cooking, leaving burners on, etc.)

□ Repeating the same question or comment

□ Trouble finding the right word

□ Getting lost

□ Confused as to time and/or place

□ Does not recognize acquaintances or family members

□ Needs help with personal care (bathing, changing clothes, grooming, toileting, etc.)

□ Other: _____

When were the changes first noticed? _____

At what age or in what year did the changes begin? _____

Did anything happen just before the changes began? (e.g., surgery, head injury, death of a loved one)
_____

Was the onset sudden? ____ Or was the onset gradual/slow and difficult to know when it began? ____

Was a doctor ever consulted? _____ If so, who? _____ When? _____
What was the diagnosis? _____ Were drugs prescribed? _____

What has been the course of the memory problems? _____ Got worse over time
_____ Did not get worse over time

Any problems with brain functioning other than memory?
(Please explain if applicable)

_____

_____

_____