OPAL Institute, Oregon Passionate Aging and Living
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BACKGROUND INFORMATION

Name: _____ Age: ____ Birthdate: _____ 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: _____ Primary lifetime occupation_____

Are you functioning adequately at your current job? Yes ___ No ___ Uncertain ___

Date retired: _____

How you are currently financially supported: ___ self (or partner) working ___ retirement savings
___ social security ___ disability ___ seeking disability ___ financially challenged

Military Service: Branch _____Year enlisted: _____ Year discharged: _____ Saw combat? Y / N

RELATIONSHIP HISTORY

Marital Status: _____ Number of previous marriages/significant relationships _____

Significant other's name _____ Significant other's residence (if different) _____

Significant other's health status: POOR FAIR GOOD DECEASED

Children's Name	Age	Place of Residence	Comment (e.g., not in communication, deceased, etc.)

# of Grandchildren ____ # Great-grandchildren ____ Does someone have POA on your behalf? _____

Other significant people: _____

All Doctors, Therapists or other Providers

Name	Specialty	Clinic Location

Please circle if you have experienced any of the following:

neurological disease	Parkinson's disease	seizure/epilepsy	hearing impairment
tremor	head trauma	osteoporosis	visual impairment
stroke (date _____)	high blood pressure	high cholesterol	ADHD/ADD
heart disease	heart attack (date _____)	urinary incontinence	HIV/AIDS
diabetes	arthritis	lung disease	chronic UTIs
sleeping disorder	cancer	thyroid disease	menopause
chronic pain	prostate problems	sexual problems	falls
childhood learning problems	Motor vehicle accidents (date _____)		head trauma

Other Significant Health Conditions: (attach additional sheet if necessary) _____

Brain Imaging (MRI/CT/PET), date, and result _____

Who in your biological family has had dementia or memory problems? _____
What type of dementia? Please circle: Alzheimer 's disease – vascular dementia – unknown – other _____

Mental Health History / Concerns: _____

Psychiatric hospitalizations and dates _____ Family psych history? _____

Current medications for mental health problems: _____
Past medications for mental health problems: _____

Counseling (provider, start/end dates) _____

Psychiatric prescriber (provider, clinic, 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) _____

Have you ever been abused? __Physically __Mentally __Sexually __Never If so, who was the abuser?

LIFESTYLE

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

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?

Has anyone expressed concern about your use of a substance? _____ If so, who, and what was the concern?

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: _____

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 diet? _____

Describe your current exercise routine:_____

Are you exercising enough to be healthy? _____ Are you at a healthy body weight? _____

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

What do you do for fun? _____

Current support network: _____

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? _____ Do you meditate? _____

Have you executed an advanced directive? _____ Have you completed relevant documents with an attorney? ____

Do you need assistance with any of these things?
Meal preparation – Medication management – Telephoning – Housekeeping – Laundering – Shopping – Transportation – Home Maintenance – Reading – Leisure planning – Walking – Bathing – Toilet use – Dressing Eating – Transfers – Grooming – Other: _____

Please circle a level of impairment (none – severe) for each possible symptom

Symptom	None 0	Questionable 0.5	Mild 1	Moderate 2	Severe 3
Memory	No memory loss or slight; inconsistent forgetfulness	Consistent slight forgetfulness; partial recollection of events; "benign" forgetfulness	Moderate memory loss; more marked for recent events; defect interferes with everyday activity	Severe memory loss, only highly learned material retrained; new material rapidly lost	Severe memory loss only fragments remain
Orientation	Fully oriented	Fully oriented but with slight difficulty with time relationships	Moderate difficulty with time relationships; oriented for place; may have geographic disorientation elsewhere	Severe difficulty with time relationships; usually disoriented to time, often to place	Oriented to person only
Judgment and Problem Solving	Solves everyday problems and handles business and financial affairs well; judgment good in relation to past performance	Slight impairment in solving problems, similarities and differences	Moderate difficulty in handling problems, similarities and differences; social judgment usually maintained	Severely impaired in handling problems, similarities and differences; social judgment usually impaired	Unable to make judgments or solve problems
Community Affairs	Independent function as usual in job, shopping, volunteer and social groups	Slight impairment in these activities	Unable to function independently at these activities though may still be engaged in some; appears normal to casual inspection	No pretense of independent function at home; appears well enough to be taken to functions outside the family home	Appears too ill to be taken to functions outside the family home
Home and Hobbies	Life at home, hobbies and intellectual interests well maintained	Life at home, hobbies and intellectual interests slightly impaired	Mild but definite impairment of functions at home; more difficult chores, and complicated hobbies and interests abandoned	Only simple chores preserved; very restricted interests, poorly maintained	No significant function in the home
Personal Care	Fully capable of self-care		Needs prompting	Requires assistance in dressing, hygiene, and keeping of personal effects	Requires much help with personal care; frequent incontinence

Medications: Please circle C–Current or P–Past

	Brand Name (Generic)
C / P	Benedryl (diphenhydramine)
C / P	Ditropan (oxybutynin)
C / P	Vesicare (solifenacin)
C / P	Aricept (donepezil)
C / P	Exelon (rivastigmine)
C / P	Namenda (memantine)
C / P	Inderal (propranalol)
C / P	Catapres (clonidine)
C / P	Elavil (amitriptyline)
C / P	Aventyl (nortriptyline)
C / P	Tofranil (imiprimine)
C / P	Xanex (alprazolam)
C / P	Ativan (lorazepam)
C / P	Restoril (temazepam)
C / P	Klonopin (clonazepam)
C / P	Valium (diazepam)
C / P	Ambien (zolpidem)
C / P	Advil (ibuprofen)
C / P	Wellbutrin (bupropion)
C / P	Remeron (mirtazapine)
C / P	Cymbalta (duloxetine)
C / P	Tysabri (natalizumab)
C / P	Gilenya (fingolimod)
C / P	Avonex or Rebif (interferon beta-1a)
C / P	Ocrevus (ocrelizumab)

Cont'd	Brand Name (Generic)
C / P	Paxil (paroxetine)
C / P	Desyrel (trazodone)
C / P	Sinemet (carbidopa-levodopa)
C / P	Requip (ropinirole)
C / P	Effexor (venlafaxine)
C / P	Celexa (citalopram)
C / P	Prozac (fluoxetine)
C / P	Zoloft (sertraline)
C / P	Buspar (buspirone)
C / P	Eskalith (lithium carbonate)
C / P	Depakote (divalproex)
C / P	Neurontin (gabapentin)
C / P	Lamictal (lamotrigine)
C / P	Ritalin (methylphenidate)
C / P	Haldol (haloperidol)
C / P	Thorazine (chlorpromazine)
C / P	Seroquel (quetiapine)
C / P	Risperdal (risperidone)
C / P	Abilify (aripiprazole)
C / P	Betaseron (interferon beta)
C / P	Copaxone (glatiramer)
C / P	Novantrone (mitoxantrone)
C / P	Tecfidera (dimethyl fumarate)
C / P	Zinbryta (daclizumab)
C / P	Xadago (safinamide)

Please complete the following (or attach a list of all current medications)

Medication Name	Dosage	Start Date