

# CARE PARTNER FORM

## Memory and Brain Wellness Clinic

### NPI-Q & Care Partner Concerns

**Important:** This form is to be filled out by a **CARE PARTNER** (for example a family member or friend - not the patient). Please fill out both front and back.

Please answer the following questions based on recent behaviors. Circle "Yes" only if the <b>symptom(s) has been present in the last month</b> . Otherwise, circle "No". For each item marked "Yes", please rate the <b>SEVERITY</b> of the symptom as <b>mild, moderate, or severe</b> .	Symptom present?		Severity (if symptom present)		
	Yes (1)	No (0)	Mild (1)	Mod. (2)	Sev. (3)
<b>Delusions:</b> Does the patient have false beliefs, such as thinking that others are stealing from him or her or planning to harm him or her in some way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hallucinations:</b> Does the patient have hallucinations? Does he or she seem to hear or see things that are not there? Does he or she talk to people who are not there?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Agitation or Aggression:</b> Is the patient stubborn and resistive to help from others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Depression or Dysphoria:</b> Does the patient seem sad or act as if he or she is in sad or low spirits? Does he or she cry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Anxiety:</b> Does the patient become upset when separated from you? Does he or she have any other signs of nervousness or anxiety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Elation or Euphoria:</b> Does the patient appear to feel too good or act excessively happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Apathy or Indifference:</b> Does the patient seem less interested in his or her usual activities or in the activities and plans of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Disinhibition:</b> Does the patient seem to act with "fewer filters"? For example, is he or she unusually frank with words? Does he or she get too close physically or acts embarrassingly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Irritability or Lability:</b> Is the patient impatient and cranky? Does he or she have difficulty coping with delays or waiting for planned activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Motor Disturbance:</b> Does the patient engage in repetitive activities such as pacing around the house, handling items over and over, or doing other things repeatedly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nighttime Behaviors:</b> Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Appetite and Eating:</b> Has the patient lost or gained weight, or had a change in the type of food he or she likes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROVIDER SIGNATURE	PRINT NAME	PAGER	NPI	TIME	DATE
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PLACE PATIENT LABEL HERE

**UW Medicine**  
 Harborview Medical Center – University of Washington Medical Center  
 UW Neighborhood Clinics – Valley Medical Center  
 University of Washington Physicians      Seattle, Washington

**M&BW CAREGIVER QUESTIONNAIRE**

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WHITE - MEDICAL RECORD

