Mountain Memory Assessment

Name: _____

Date: _____

Date of Birth: _____

Handedness: Right Left Ambidextrous

Background Information Form

Current medications:

Please list all prescribed drugs, over-the-counter remedies, vitamins, and supplements		
Medication	Dose	Reason / desired effect

Current symptoms and problems:

Please check any of the following that apply to you:

- ☐ Memory problems
- ☐ Word-finding problems
- ☐ Difficulty speaking
- ☐ Difficulty understanding speech
- ☐ Tension headaches
- ☐ Migraine headaches
- ☐ Arthritis
- ☐ Other pain
- ☐ Vision loss
- ☐ Wear glasses or contact lenses
- ☐ Other vision problems
- ☐ Hearing loss
- ☐ Need a hearing aid
- ☐ Ringing or buzzing in ears
- ☐ Tremor
- ☐ Paralysis or severe weakness
- ☐ Loss of sensation
- ☐ Numbness or tingling sensation
- ☐ Dizziness
- ☐ Spinning sensation
- ☐ Lightheadedness
- ☐ Problems with balance
- ☐ Unsteady on feet
- ☐ Change in sense of taste
- ☐ Change in sense of smell
- ☐ Speech problems
- ☐ Writing problems
- ☐ Problems paying bills
- ☐ Problems driving

Medical History:

Please list any serious injuries, including any head injury			
Year	Injury	Year	Injury

Medical History (continued):

Please check the box in front of each condition you have ever had.

- ☐ Alzheimer's disease
- ☐ Parkinson's disease
- ☐ Seizures
- ☐ Stroke
- ☐ TIA (mini-stroke)
- ☐ Brain hemorrhage
- ☐ Head injury
- ☐ Encephalitis
- ☐ Meningitis
- ☐ Hypoxia
- ☐ Other neurological disorder or disease
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Coronary artery bypass surgery
- ☐ Atrial fibrillation
- ☐ Heart valve disease
- ☐ Heart attack
- ☐ Other heart disease
- ☐ Peripheral vascular disease (including thrombosis)
- ☐ Fainting spells
- ☐ High blood pressure (hypertension)
- ☐ Low blood pressure (hypotension)
- ☐ High cholesterol (hyperlipidemia)
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Elevated homocysteine levels
- ☐ Osteoporosis
- ☐ Problems with uterus or ovaries
- ☐ Have gone through menopause
- ☐ Testosterone deficiency (if male)
- ☐ Prostate problems
- ☐ Heat stroke
- ☐ Sleep apnea
- ☐ Asthma
- ☐ Other lung disease
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Other liver disease
- ☐ Kidney disease
- ☐ HIV / AIDS
- ☐ Syphilis
- ☐ Electric shock / lightning strike
- ☐ Fibromyalgia
- ☐ Chronic fatigue syndrome
- ☐ Chronic pain
- ☐ Alcohol abuse
- ☐ Drug or substance abuse
- ☐ Other medical problem (please describe)

Have you ever had cancer? _____ If so, please give details including the type of cancer, when it was diagnosed, how it was treated, and how long it has been in remission.

Have you ever had chemotherapy? ☐ yes ☐ no	Have you ever had radiation therapy? ☐ yes ☐ no

Surgical history and other hospitalizations

Year	Operation or illness	Year	Operation or illness

Family Medical History:

Please indicate the number of your immediate family members (father, mother, sisters, brothers, or children) with the risk factor specified. (0, 1, 2 or more)

☐ Alzheimer's disease	☐ Heart disease	☐ Hypoglycemia
☐ Dementia due to any cause	☐ Peripheral vascular disease (including thrombosis)	☐ Cancer
☐ Downs syndrome	☐ Elevated homocysteine levels	☐ Alcoholism
☐ Parkinson's disease	☐ High blood pressure (hypertension)	☐ Drug or other substance abuse
☐ Stroke or TIA (mini-stroke)	☐ Low blood pressure (hypotension)	☐ Depression
☐ Brain hemorrhage	☐ High cholesterol (hyperlipidemia)	☐ Anxiety
☐ Seizures	☐ Diabetes	☐ Other emotional problems
☐ Other neurological disorder or disease		

Psychiatric history:

Have you ever had significant depression, anxiety, nerves, or other emotional problems? ☐ Yes ☐ No

Outpatient treatment for emotional problems

Year(s)	Reason	Medication or counseling	Treatment length	Was it helpful?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Inpatient treatment (hospitalization) for emotional problems

Year(s)	Reason	Hospital or clinic	Treatment length	Was it helpful?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Psychosocial History:

City & state where raised:

Person(s) who raised you:	biological ☐ ☐ mother / father	Step ☐ ☐ mother / father	Grand ☐ ☐ mother / father	Adoptive ☐ ☐ mother / father	Others ☐

Marital status: How long?	☐ Now married ☐ years	☐ Widowed ☐ years	☐ Divorced ☐ years	☐ Separated ☐ years	☐ Never married

If not married, are you in an intimate relationship? ☐ Yes ☐ No If yes, how many years? ☐

Number of children: ☐ How often do you see them?

Briefly describe how you spend your free time (hobbies, recreational interests, etc.):

Primary and secondary education:

What is the highest grade you **completed**? ☐	Did you graduate? ☐ Yes ☐ No	G.E.D.? ☐ Yes ☐ No
Were your grades ☐ Below Average ☐ Average ☐ Above Average ☐ Don't remember		
Did you ever repeat a grade? ☐ Yes ☐ No		
Were you ever told you had a learning disability? ☐ Yes ☐ No	ADHD? ☐ Yes ☐ No	
Were you ever in any special classes at school? ☐ Yes ☐ No		
If yes, what kind?		
During which grades?		
Were you ever: ☐ expelled? ☐ suspended?		

College education:

College	Years attended	Degree	Major(s)	G.P.A.

Vocational History: (start with current or most recent job and work backwards)

Job Title:	Employer:	
Dates of employment: From ______/_____ to ______/______ Month/year Month/year	Part time / full time (circle one)	Temporary / Permanent (circle one)
Description of duties:		
Job Title:	Employer:	
Dates of employment: From ______/_____ to ______/______ Month/year Month/year	Part time / full time (circle one)	Temporary / Permanent (circle one)
Description of duties:		
Job Title:	Employer:	
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Description of duties:		
Job Title:	Employer:	
Dates of employment: From ______/_____ to ______/______ Month/year Month/year	Part time / full time (circle one)	Temporary / Permanent (circle one)
Description of duties:		

Health Habits And Personal Safety:

Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (climbing stairs, walk 3 blocks)			
	☐ Moderate (walking briskly, mowing the lawn, dancing, swimming for recreation, or bicycling)			
	☐ Vigorous (jogging, heavy yard work, high-impact aerobics, swimming laps, bicycling uphill)			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?			☐ Yes ☐ No
	If yes, what kind?			
	How many drinks per week? ☐			
	When was the last time you had more than 4 drinks in one day?			
	Have you ever felt you should cut down on your drinking?			☐ Yes ☐ No
	Have people annoyed you by criticizing your drinking?			☐ Yes ☐ No
	Have you ever felt bad or guilty about your drinking?			☐ Yes ☐ No
	Have you ever had a drink first thing in the morning (as an "eye opener") to steady your nerves or get rid of a hangover?			☐ Yes ☐ No
	Are you prone to "binge" drinking?			☐ Yes ☐ No
	Do you drive after drinking?			☐ Yes ☐ No
	Has your drinking caused family problems?			☐ Yes ☐ No
Tobacco	Do you use tobacco?			☐ Yes ☐ No
	☐ Cigarettes – packs/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years you've used tobacco	Year quit:		
Drugs	Do you currently use recreational or street drugs?			☐ Yes ☐ No
	Have you ever used recreational or street drugs?			☐ Yes ☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes ☐ No
Personal Safety	Do you live alone?			☐ Yes ☐ No
	Do you drive?			☐ Yes ☐ No
	Do you have frequent falls?			☐ Yes ☐ No
	Do you have vision or hearing loss?			☐ Yes ☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes ☐ No
	Do you have a Durable Power of Attorney?			☐ Yes ☐ No
	Physical and mental abuse have also become major public health issues in this country. This can take the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes ☐ No
Legal	Have you ever been arrested or in trouble with the law?			☐ Yes ☐ No
	Are you currently involved in any criminal or civil legal proceedings			☐ Yes ☐ No

Current and recent emotional functioning:

Check the box in front of each problem you have experienced during the past two weeks.	
☐ Feeling anxious	☐ Feeling sad or blue
☐ Feeling nervous	☐ Feeling lonely
☐ Worrying a lot	☐ Feeling hopeless
☐ Loss of temper	☐ Feeling guilty
☐ Nightmares or frightening dreams	☐ Feeling worthless
☐ Difficulty thinking or concentrating	☐ Fatigue
☐ Mind going blank	☐ Loss of energy
☐ Irritability	☐ Trouble falling asleep
☐ Muscle tension	☐ Trouble staying asleep
☐ Restlessness	☐ Sleeping more than usual
☐ Feeling keyed up or on edge	☐ Decreased appetite
☐ Difficulty making decisions	☐ Increased appetite
☐ Loss of interest in things you used to enjoy	☐ Recurrent thoughts of death
☐ Difficulty making friends	☐ Wishing you were dead
☐ Difficulty keeping friends	☐ Thoughts of suicide
☐ Shyness	☐ Wanting to hurt or kill someone
☐ Seeing things (ghosts, visions, bugs, animals, people) others don't see	☐ Hearing voices others don't hear

I read all of the items on this form and answered them to the best of my ability.

Signature of person completing this form

Date

(Please write the name and relationship to the client if anyone else helped with the answers)

Relationship (if not client)