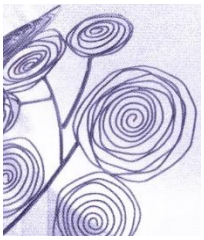

Orr & Associates Memory Clinic

720 Main Street #204 Mendota Heights, MN. 55118
Phone Number 651-528-8183 ◆ Fax Number 651-528-8184 ◆Email orrmemoryclinic.com
◆ Dr. William Orr MD, PhD. ◆
◆ Sue Bikkie DNP ◆ Jana Gegen DNP ◆ Carly Curry PMHNP ◆Heidi Hoppe PMHNP

Welcome to Orr & Associates!! In order to best serve your needs, we ask that you fully complete this form. In addition, it is important that you bring- or have sent- your most recent, relevant medical records. Please also bring a complete medication list. It is also imperative that a family member- or someone who knows you well- accompany you to the appointment**.** **NOTE**: If there is a legal guardian or conservator, that person **must** be present at the appointment.

Today's Date: _____

Patient Name: _____ **DOB:** _____

What are the concerns that bring you to the clinic?

_____
_____

What are your goals for this appointment?

_____
_____

Advanced Directives: Check those that apply, if any:

___DNR/DNI ___Living Will ___Power of Attorney ___Legal Guardian

**Bring copies of Living Will, Power of Attorney, and or Guardianship/Conservatorship if applicable

Primary Care Physician: _____ **Clinic:** _____

Specialists: _____

Current Medical Problems: _____

Recent Hospitalizations: _____

Current Height: _____ **Current Weight:** _____

Have you received the flu shot? _____

Have you received the pneumonia vaccine? _____

Drug Allergies: _____

Pharmacy Name: _____ **Location**: _____

Current Medications: (List name, dosage and start date; you may use the back of this sheet, if needed- or attach a current medication list):

_____
_____

****Who administers your medication?** _____

****Do you ever forget to take your medication?** _____ **If so, how many times a week?** _____

Personal Medical History: (Check any of the following that apply- or for which you have a history.)

__Anemia __Asthma/Respiratory __Cancer __Chronic Fatigue __Chronic Pain __Diabetes __Epilepsy or Seizures
__Fibromyalgia __Head Trauma __Heart Disease __High Blood Pressure __High Cholesterol __Head Trauma
__Kidney Disease __Liver Disease __Thyroid Disease __Other: _____
Is there any history of brain injury, being knocked unconscious, or seizures? _____
If yes, Explain: _____
Do you have any visual problems? _____
Do you have any hearing difficulties? _____ Do you use hearing aids? _____
Do you have any problems chewing? _____ Swallowing? _____ Do you use dentures? _____
Do you have any urinary or bowel incontinence? _____
Do you have any problems walking? _____ Standing? _____ Need Assistance? _____
Do you use a walking assistance device? ___Yes ___No What device/s? _____
Have you had any falls in the past year? _____ Please describe when/where and if any injuries of falls in last year: _____

Mental Health

Current Symptoms Checklist: ___Depressed mood ___Unable to enjoy activities ___Loss of interest
___Avoidance ___Crying spells ___Concentration/Forgetfulness ___Increased irritability ____Decreased libido
___Excessive worry ___Anxiety attacks ___Excessive guilt ___Sleep disturbance ___Change in appetite
___Excessive energy ___Racing thoughts ___Impulsivity ___Increased risky behavior ___Increased libido
___Suspiciousness ___Hallucinations ___Delusions Other: _____

Do you currently feel that you don't want to live? ___Yes ___No **If concerns of safety, call 9-1-1**
Have you ever had thoughts or feelings that you didn't want to live? ___Yes ___No
Have you ever attempted suicide before? ___Yes ___No When? _____
Have you had past outpatient treatment? ___Yes ___No If yes, please describe when, by whom, and nature of treatment: _____
Current Therapist: _____
Current Psychiatrist: _____
Have you had any psychiatric hospitalizations? ___Yes ___No If yes, please describe when, for what reason, and where you were hospitalized: _____
_____

Past Psychiatric Medication- Please list any psychiatric medications you have taken in the past:

Antidepressants: _____
Mood Stabilizers: _____
Antipsychotics: _____
Sedatives/Hypnotics: _____
ADHD medications: _____
Anti-anxiety medications**:** _____

Family Psychiatric/Neuropsychiatric History: Has anyone in your family been diagnosed or treated for:

Bipolar Disorder, Depression, Anxiety, Schizophrenia, Post-Traumatic Stress, Violence, Alcohol abuse, Other Substance Abuse, Suicide, Dementia or other. If yes, please identify (who/what/relationship to you):

_____
_____

Substance Use:

Do you currently use any tobacco products such as cigarettes, cigars, pipes, or chewing tobacco? ___Yes ___No If yes, what, how much, how often, for how long? _____

Do you drink coffee/caffeine? ___Yes ___No If yes, how many cups per day? _____

Do you drink Alcohol? ___Yes ___No If yes, how much a day/week? _____

Are you currently using any alcohol, recreational drugs, or misusing prescription medication? ___Yes ___No If yes, please describe: _____

Have you ever been treated for alcohol or drug use? ___Yes ___No If yes, for what substance? _____
When/where were you treated? _____

Relationship History and Current Family:

Where were you born? _____ Who raised you? _____

Are you currently ___Married ___Divorced ___Single ___Widowed ___Partnered How long? _____

Have you had prior marriages? ___Yes ___No If yes, how many? ____ How long? _____

Do you have children? ___Yes ___No If yes, list ages and gender: _____
_____

Occupational History:

Are you currently: ___Working? ___ Unemployed ___Disabled ___Retired ____Other

What is/was your occupation? _____

What is/was your spouse or significant other's occupation? _____

Educational History:

Did you attend college? ___Yes ___No If yes, where? _____

What is your highest level of education or degree attained? _____

Any history of learning problems or tutoring? ___Yes ___No What age? _____

Military History:

Have you ever served in the military? ___Yes ___No If yes, what branch? _____

Did you serve in combat? ___Yes ___No When _____ Where _____

Honorable discharge? ___Yes ___No Other type of discharge? _____

Spirituality/Religion:

Do you practice a religion or are you a spiritual person? ___Yes ___No

What affiliation, if any? _____

Does it play a part in your coping treatment? ___Yes ___No

Legal History:

Have you ever been arrested? ___Yes ___No If yes, what for: _____ When _____

Do you have any pending legal problems? ___Yes ___No. If yes, _____

Daily Activities:

Do you need assistance with any of the following:

Grocery Shopping: ___No ___Some ___Totally dependent
Balancing Checkbook: ___No ___Some ___Totally dependent
Paying Bills: ___No ___Some ___Totally dependent
Housework: ___No ___Some ___Totally dependent
Meal Preparation: ___No ___Some ___Totally dependent
Dressing: ___No ___Some ___Totally dependent
Eating: ___No ___Some ___Totally dependent
Personal Hygiene: ___No ___Some ___Totally dependent

Are the above activities effected by decreased vision, hearing, sleep and/or pain? ___Yes ___No
If yes, please describe: _____

If assistance needed, who is/are your caregiver/s? _____

What do you do most of your days? _____

_____

Cognitive Status: Briefly describe any significant memory problems (forgetting appointments, medications, familiar directions, cooking accidents, other):

_____

_____

Briefly describe any problems with language (word finding, speech, ability to read, ability to understand others):

_____

Briefly describe any problems with personality changes, decision making, impulsivity, socially inappropriate behavior, sexually aggressive behavior, combative behavior: _____

_____

Are you still driving? ___Yes ___No Do you limit your driving in any way? _____

Have you had any recent problems driving? (Tickets, getting lost, accidents- and when):

_____

Is there anything else you want your provider to know? _____

_____

Is anyone currently neglecting you or abusing you physically, emotionally and/or sexually? _____

Do you have a history of being physically, emotionally, and/or physically abused or neglected? _____

Form completed by: _____ Date: _____

Signature of patient: _____ Date: _____