



# Orr & Associates Memory Clinic

2308 Ford Parkway #417 St. Paul, MN 55116

Phone Number 651-528-8183 • Fax Number 651-528-8184 • Email info@orrmemoryclinic.com

- Dr. William Orr MD, PhD. • Sue Bikkie DNP • Heidi Hoppe DNP •

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?**

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**What are your goals for this appointment?**

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**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):

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**\*\*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: \_\_\_\_\_