



Orr & Associates Memory Clinic

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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: _____