



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 |
|------------|------|-------------------------|
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Current symptoms and problems:

Please check any of the following that apply to you:

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

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.

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

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? | <input type="checkbox"/> yes | <input type="checkbox"/> no | Have you ever had radiation therapy? | <input type="checkbox"/> yes | <input type="checkbox"/> 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)

| | | |
|---|---|--|
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Dementia due to any cause | <input type="checkbox"/> Peripheral vascular disease (including thrombosis) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Downs syndrome | <input type="checkbox"/> Elevated homocysteine levels | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> High blood pressure (hypertension) | <input type="checkbox"/> Drug or other substance abuse |
| <input type="checkbox"/> Stroke or TIA (mini-stroke) | <input type="checkbox"/> Low blood pressure (hypotension) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Brain hemorrhage | <input type="checkbox"/> High cholesterol (hyperlipidemia) | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other emotional problems |
| <input type="checkbox"/> 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? |
|---------|--------|--------------------------|------------------|--|
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Inpatient treatment (hospitalization) for emotional problems

| Year(s) | Reason | Hospital or clinic | Treatment length | Was is helpful? |
|---------|--------|--------------------|------------------|--|
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Psychosocial History:

City & state where raised:

| | | | | | |
|---|--|--|---|--|--|
| Person(s) who raised you: | <input type="checkbox"/> biological mother / father | <input type="checkbox"/> Step mother / father | <input type="checkbox"/> Grand mother / father | <input type="checkbox"/> Adoptive mother / father | <input type="checkbox"/> Others |
| Marital status: | <input type="checkbox"/> Now married | <input type="checkbox"/> Widowed | <input type="checkbox"/> Divorced | <input type="checkbox"/> Separated | <input type="checkbox"/> Never married |
| How long? | <input type="text"/> years | <input type="text"/> years | <input type="text"/> years | <input type="text"/> years | |
| If not married, are you in an intimate relationship? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | If yes, how many years? <input type="text"/> | | |

Number of children:

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

Primary and secondary education:

| | | |
|---|---|---|
| What is the highest grade you completed ? <input style="width:40px;" type="text"/> | Did you graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No | G.E.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Were your grades <input type="checkbox"/> Below Average <input type="checkbox"/> Average <input type="checkbox"/> Above Average <input type="checkbox"/> Don't remember | | |
| Did you ever repeat a grade? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Were you ever told you had a learning disability? <input type="checkbox"/> Yes <input type="checkbox"/> No | | ADHD? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Were you ever in any special classes at school? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If yes, what kind? | | |
| During which grades? | | |
| Were you ever: <input type="checkbox"/> expelled? <input type="checkbox"/> suspended? | | |

College education:

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

Health Habits And Personal Safety:

| | | | | | | | | |
|------------------------|--|---------------------------------|------------------------------|-------------------------------|----------------------|--------------|----------------------|----------------|
| Exercise | <input type="checkbox"/> Sedentary (No exercise) | | | | | | | |
| | <input type="checkbox"/> Mild exercise (climbing stairs, walk 3 blocks) | | | | | | | |
| | <input type="checkbox"/> Moderate (walking briskly, mowing the lawn, dancing, swimming for recreation, or bicycling) | | | | | | | |
| | <input type="checkbox"/> Vigorous (jogging, heavy yard work, high-impact aerobics, swimming laps, bicycling uphill) | | | | | | | |
| Caffeine | <input type="checkbox"/> None | <input type="checkbox"/> Coffee | <input type="checkbox"/> Tea | <input type="checkbox"/> Cola | | | | |
| | # of cups/cans per day? | | | | | | | |
| Alcohol | Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | If yes, what kind? | | | | | | | |
| | How many drinks per week? <input type="text"/> | | | | | | | |
| | When was the last time you had more than 4 drinks in one day? <input type="text"/> | | | | | | | |
| | Have you ever felt you should cut down on your drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | Have people annoyed you by criticizing your drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | Have you ever felt bad or guilty about your drinking? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | Are you prone to "binge" drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | Do you drive after drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | Has your drinking caused family problems? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Tobacco | | | | | | | | |
| | <input type="text"/> | Cigarettes – packs/day | <input type="text"/> | Chew - #/day | <input type="text"/> | Pipe - #/day | <input type="text"/> | Cigars - #/day |
| | <input type="text"/> | # of years you've used tobacco | | Or year quit: | | | | |
| Drugs | Do you currently use recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | Have you ever used recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | Have you ever given yourself street drugs with a needle? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Personal Safety | Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | Do you drive? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | Do you have frequent falls? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | Do you have vision or hearing loss? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | Do you have an Advance Directive or Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | Do you have a Durable Power of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Legal | Have you ever been arrested or in trouble with the law? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | Are you currently involved in any criminal or civil legal proceedings? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |

Current and recent emotional functioning:

Check the box in front of each problem you have experienced during the past two weeks.

- | | |
|--|---|
| <input type="checkbox"/> Feeling anxious | <input type="checkbox"/> Feeling sad or blue |
| <input type="checkbox"/> Feeling nervous | <input type="checkbox"/> Feeling lonely |
| <input type="checkbox"/> Worrying a lot | <input type="checkbox"/> Feeling hopeless |
| <input type="checkbox"/> Loss of temper | <input type="checkbox"/> Feeling guilty |
| <input type="checkbox"/> Nightmares or frightening dreams | <input type="checkbox"/> Feeling worthless |
| <input type="checkbox"/> Difficulty thinking or concentrating | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Mind going blank | <input type="checkbox"/> Loss of energy |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Trouble falling asleep |
| <input type="checkbox"/> Muscle tension | <input type="checkbox"/> Trouble staying asleep |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Sleeping more than usual |
| <input type="checkbox"/> Feeling keyed up or on edge | <input type="checkbox"/> Decreased appetite |
| <input type="checkbox"/> Difficulty making decisions | <input type="checkbox"/> Increased appetite |
| <input type="checkbox"/> Loss of interest in things you used to enjoy | <input type="checkbox"/> Recurrent thoughts of death |
| <input type="checkbox"/> Difficulty making friends | <input type="checkbox"/> Wishing you were dead |
| <input type="checkbox"/> Difficulty keeping friends | <input type="checkbox"/> Thoughts of suicide |
| <input type="checkbox"/> Shyness | <input type="checkbox"/> Wanting to hurt or kill someone |
| <input type="checkbox"/> Seeing things (ghosts, visions, bugs, animals, people) others don't see | <input type="checkbox"/> 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)