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| --- | --- |
|  | **Family/Caregiver Questionnaire** |
|  |
| Patient Name: |  | DOB: |  | DOS: |  |
| Your Name: |  | Relationship: |  |  |

*Please fill out as much as you are able. Thank you!*

1. How is the patient doing since the last visit and/or medication change? Better Worse Same

Explain:

1. Does the patient have any of the following? (Circle all appropriate answers)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Depression | Lack of interest | Crying spells | Isolation | Restlessness | Anxiety |
| Paranoia | Suspiciousness | Irritability | Agitation | Hallucinations | Confusion |
| Forgetfulness | Getting lost | Repeating | Wandering | Needing more assistance |
|  |  |  |  |  |
| Nausea/Vomiting | Poor appetite | Weight loss | Constipation | Diarrhea | Weight gain |
| Light headedness | Unsteadiness | Falls | Dizziness | Weakness | Blurred vision |
| Insomnia | Sedation | Sleepiness | Dreams | Nighttime Confusion/Wandering |
| Incontinence | Dry Mouth | Palpitation | Breathing Difficulties | Heart Problems |

1. Describe above behaviors/symptoms:
2. Does the behavior happen during any particular period of the day?
3. Are there things/situations that make above behavior more frequent or intense?
4. Are there things/situations that help or improve above behavior?
5. Does patient accept redirection? If yes, then from who?
6. If patient is agitated, is there any physical aggression?
7. Does patient ever express suicidal ideas or intentions?
8. Are there any safety concerns?
9. Do you think the patient is taking medications regularly?
10. Do you think the psychotropic medications are having any benefits and/or adverse effects?
11. Any new medical problems or concerns since last visit with us?
12. What are your questions or concerns for today’s visit?

Please use back of this paper if more space is needed.