Washington Regional

Memory Disorders Clinic

Patient Registration

Patient Name: _____
Last First Middle

Address: _____Apt: _____

City: _____**State**: _____**Zip Code**: _____

Home Phone: _____**Cell Phone**: _____

Date of Birth: _____**Age**: _____**Social Security #**_____

Sex: ☐ Male ☐ Female **Preferred Language**: _____

Occupation: _____ **Employer**: _____

Is the patient a Veteran: : ☐**Yes** ☐ **No** **Is the patient Retired:** ☐**Yes** ☐ **No**

Retirement Date: _____

Marital Status: ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

Race: ☐ White ☐ African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander

☐ Native American Indian/Alaskan ☐ Hispanic ☐ Decline ☐ Unknown

Email Address: _____

Preferred method of communication: ☐ Home Phone ☐ Cellphone Text ☐ Email

Primary Physician: _____ **Referring Physician**: _____

Employer: _____

Work Phone: _____**Ext.**: _____**Occupation**: _____

Is the Patient the Guarantor: ☐ **Yes** ☐ **Other: (fill out below)**

Responsible Party: _____ **DOB:** _____

Relationship to Patient: _____**SS#:** _____

Address: _____**Phone:** _____
Street **City** **State**

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EMERGENCY CONTACT INFORMATION

Emergency Contact: _____**Relationship to Patient**: _____

Emergency Contact Address_____
Street City Zip

Emergency Contact Home Phone: _____ **Cell Phone**: _____

GENERAL INFORMATION

Have you ever been seen as a patient at one of our Washington Regional Systems Clinics? ☐ Yes ☐ No

If Yes, When: _____ Where: _____

RELEASE OF INFORMATION (spouse, children, parents, etc.)

Who may we discuss your information such as medical issues/care, results, billing, etc. with:

Name: _____ **Relationship to Patient**: _____

Name: _____ **Relationship to Patient**: _____

Name: _____ **Relationship to Patient**: _____

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in m care. I give my permission for messages to be left on my answering machine or sent by email. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System and their designees, as may in their professional judgment by necessary to the above-named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility of obtain my medication history electronically.

_____ Date: _____
Signature

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PRIMARY INSURANCE:

Patient's relationship to main policy holder: ☐ self ☐ spouse ☐ other

Name of insurance company_____

Insurance company address_____

City_____State_____Zip Code_____

ID#_____Group#_____

Insurance company's phone number_____

Main holder's name_____

Main holder's address_____

City_____State_____Zip Code_____

Main holder's social security number_____

SECONDARY INSURANCE:

Patient's relationship to main policy holder: ☐ self ☐ spouse ☐ other

Name of insurance company_____

Insurance company address_____

City_____State_____Zip Code_____

ID#_____Group#_____

Insurance company's phone number_____

Main holder's name_____

Main holder's address_____

City_____State_____Zip Code_____

Main holder's social security number_____

Name of person completing form: _____

Relationship to patient: _____

Date completed: _____

Preferred Pharmacy: _____

Address: _____

Street City State Zip

Senior Health Clinic
12 E. Appleby Rd. | Fayetteville, AR 72703 | 479.463.4444 phone | 479.463.4499 fax | wregional.com

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HOME MEDICATION LIST INCLUDE OVER THE COUNTER MEDS AND SUPPLEMENTS

Medications (list below)	Dosage and Frequency (milligrams & times per day)	Purpose

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

11. _____

12._____

13. _____

ALLERGIES INLCUDE SEVERITY AND REACTION

1._____

2._____

3._____

4._____

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PATIENT MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY:

- ☐ Asthma
- ☐ Allergies_____
- ☐ Anemia (low blood)
- ☐ Atrial Fib.
- ☐ Blood Clot, Specify:_____
- ☐ Cancer, Type_____
- ☐ Congestive Heart Failure
- ☐ Dementia
- ☐ Diabetes
- ☐ Emphysema/Chronic Bronchitis
- ☐ Fainting/Dizziness
- ☐ Frequent/Severe Headaches
- ☐ Hearing issues, specify:_____
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Sleep Apnea: CPAP? ☐ YES ☐ NO
- ☐ Stroke/CVA
- ☐ Vision issues, specify:_____

Has the patient ever suffered a significant blow to the head? ☐ YES ☐ NO

If yes, please explain: _____

_____

Has the patient ever experienced a loss of consciousness? ☐ YES ☐ NO

If yes, please explain: _____

FUNCTIONAL HISTORY

Have you fallen in the last 6 months? ☐ YES ☐ NO

If yes how many falls? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+

In the last 6 months have you been having any trouble in the following areas?

- ☐ Ambulation/Walking
- ☐ Transfers
- ☐ Stairs
- ☐ Shopping
- ☐ Cooking
- ☐ Eating
- ☐ Bathing
- ☐ Dressing
- ☐ Toileting
- ☐ Housework
- ☐ Medications
- ☐ Driving
- ☐ Trouble Sleeping
- ☐ Other: _____

Do you use assistive devices?

- ☐ Cane
- ☐ Wheelchair
- ☐ CPAP
- ☐ Crutches
- ☐ Hearing aid
- ☐ Medical Implants
- ☐ Walker
- ☐ Splint/Brace
- ☐ Prosthetic limb
- ☐ Glasses/Contacts

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SLEEP:

Please answer about during the past month:

1. What time do you usually go to bed? _____
2. What time do you usually wake up in the morning? _____
3. How many times do you awaken during the night? _____
4. Do you snore? _____
5. Do you ever stop breathing or wake up gasping for air? _____
6. Do you ever act out your dreams? (Example: kick or punch while asleep)

   _____
7. Do you use any over the counter sleep aids? Please List:

   _____

SMOKING HISTORY:

Have you ever used tobacco products? ☐ YES ☐ NO ☐ CURRENT USE

If yes, what type of product? _____

How many years did patient smoke? _____

How many packs per day? _____

If patient stopped smoking, how many years ago? _____

DRUG USE:

Have you ever used any of the following drug types? If yes, please explain when you have used these drugs and if you are still using them.

☐ Cocaine _____

☐ Heroin _____

☐ Marijuana_____

☐ Methamphetamines _____

☐ Opioids_____

☐ Other _____

Have you ever attended drug rehabilitation? ☐ YES ☐ NO

Year of treatment(s): _____

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ALCOHOL USE:

Do you drink alcohol? ☐ YES ☐ NO ☐ FORMERLY: YEAR QUIT_____

Type of Alcohol?

☐ Beer
☐ Hard Liquor (Gin, Vodka, Whiskey, etc.)
☐ Wine

On average, how many drinks did the patient have at a time?

☐ 10 or more drinks
☐ 5 to 9 drinks
☐ 3 to 4 drinks
☐ 1 to 2 drinks

On average, how often did the patient have an alcoholic beverage?

☐ More than once a day
☐ Every day or nearly every day
☐ Three-four time a week
☐ One-two times a week, e.g. weekends only
☐ Less than once a month
☐ None

Have you ever attended alcohol rehabilitation? ☐ YES ☐ NO

FAMILY MEDICAL HISTORY:

CHECK ALL THAT APPLY & WHICH FAMILY MEMBER (EXAMPLE: MOTHER, FATHER, BROTHER, SISTER)

☐ Alzheimer's Dementia _____
☐ Vascular Dementia _____
☐ Lewy Body Dementia _____
☐ Frontotemporal Dementia _____
☐ Dementia Other _____
☐ Stroke _____

SPECIALTY PHYSICIANS: (example: Cardiologist, Rheumatologist, etc.)

Name: _____Specialty: _____

Name: _____Specialty: _____

Name: _____Specialty: _____

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SOCIAL HISTORY

FAMILY HISTORY:

Place of Birth: _____

Marital Status: Single☐ Married☐ Separated☐ Divorced☐ Partner ☐ Widowed☐

Children: ☐ YES ☐ NO

How many living? _____ Daughters___ Sons___

How many deceased? _____ Daughters____Sons___

EDUCATION/SERVICE:

Highest level of education completed?

☐ Graduate: MD, DO, PhD, EdD, JD
☐ Graduate: Master's Degree, APRN
☐ College or University Graduation
☐ Partial Business/College training (at least one year)
☐ High School Graduate
☐ Junior High School (through 8th grade)
☐ Less than seven years of school

What has been your primary occupation? _____

What is your current employment status? _____

☐ Disabled
☐ Retired/Not working
☐ Self-employed
☐ Working full-time
☐ Working part time

Is Patient a Veteran? ☐ YES ☐ NO

Branch of Service? _____

Service Dates? _____

Currently Receiving services from VA? ☐ YES ☐ NO

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HOME AND ENVIRONMENTAL:

Current living status: ☐ House ☐ Apartment ☐ Mobile Home ☐ Assisted Living

Other: _____

Is current living situation adequate? ☐ YES ☐ NO

Who lives in home? ☐ Live Alone ☐ Spouse ☐ Family ☐ Partner Other: _____

Who is primary caregiver to patient? _____

Patients main form of support? ☐ Church ☐ Family ☐ Friends ☐ Neighbors ☐ Spouse

Do you employ someone to provide care or help you in your home?

☐ YES ☐ NO

If YES, how many hours a day and how many days a week is your paid helper available for you?

_____ hours a day and _____ days a week.

Do you get help from a family member or friend in your home? ☐ YES ☐ NO

If YES, approximately how many hours a day and how many days a week is your family. member or friend available for you? _____ hours a day and _____ days a week.

Is this sufficient to meet your needs? ☐ YES ☐ NO

DRIVING:

Does the patient still have a Driver's License? ☐ YES ☐ NO

Is Patient still driving? ☐ YES ☐ NO

Do you or others have concerns about your ability to drive safely? ☐ YES ☐ NO

Approximately how many miles a week does patient drive? _____

Any tickets in the past three years? _____

Any accidents in the past three years? _____

Do you have transportation insecurity? ☐ YES ☐ NO

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ACTIVITIES AND EXERCISE:

What social activities does the patient CURRENTLY participate in?

- ☐ Art
- ☐ Bible Study
- ☐ Boating
- ☐ Church
- ☐ Cards
- ☐ Cooking
- ☐ Clubs
- ☐ Dancing
- ☐ Entertaining Friends
- ☐ Fishing
- ☐ Gambling
- ☐ Gardening
- ☐ Golf
- ☐ Motorcycles/ATV's
- ☐ Music
- ☐ Reading
- ☐ Senior Center
- ☐ Sewing
- ☐ Traveling
- ☐ Volunteer work
- ☐ Woodworking
- ☐ Other_____

What physical exercise does patient CURRENTLY participate in?

- ☐ Bike
- ☐ Exercise Class
- ☐ Gym
- ☐ Pilates
- ☐ Running
- ☐ Stationary Bike
- ☐ Swimming
- ☐ Walking
- ☐ Yoga
- ☐ Other

Exercise Frequency:

- ☐ Daily
- ☐ 1-3x a week
- ☐ 4-6x a week
- ☐ None

ADVANCE DIRECTIVES:

Legal arrangements completed by the patient: Check all that apply.

☐ Has prepared a will or living trust.

☐ Has completed a durable power of attorney for health care.

If yes, who is the substitute decision maker? _____

☐ Has completed a general power of attorney for finances.
If yes, who is the substitute decision maker? _____

☐ Has had legal advice concerning personal finances.

☐ Has arranged for care when no longer able to care for self.

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COGNITIVE HISTORY

1. Onset of cognitive/personality/behavioral changes:

   a. When did they first occur? (Year): _____

   b. Was the onset gradual or sudden? _____

2. What symptoms have been noticed: (check all that apply)

   a. Memory problems
   - ☐ Memory loss for recent events
   - ☐ Memory loss for remote events
   - ☐ Easily gets lost in familiar surroundings
   - ☐ Problems recognizing familiar persons
   - ☐ Repeats themselves or tells the same story multiple times.

   b. Language problems
   - ☐ Word finding difficulty
   - ☐ Difficulty with expressive speech
   - ☐ Difficulty with comprehending spoken or written speech
   - ☐ Decreased written expression (not due to physical limitations)
   - ☐ Increased difficulty with writing checks

   c. Attention and concentration problems
   - ☐ Increasingly forgetful
   - ☐ Becomes confused or overwhelmed in larger groups
   - ☐ Appears inattentive while driving

   d. Behavioral/personality change
   - ☐ Physical aggressiveness
   - ☐ Wandering
   - ☐ Paranoia/suspiciousness
   - ☐ Hides and hoards things
   - ☐ Hallucinations
   - ☐ Inattentive to hygiene
   - ☐ Increased worry/anxiety

   e. Depression
   - ☐ Tearful
   - ☐ Decrease in social interaction
   - ☐ Decreased participation in previously enjoyed activities
   - ☐ Increase in eating
   - ☐ Decrease in eating
   - ☐ Increase in sleep
   - ☐ Decrease in sleep

   f. Other

   Please specify: _____

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CURRENT NEEDS AS SEEN BY CAREGIVER/FAMILY

Please share your thoughts on the following issues as they relate to the patient so that we may better understand the patient's needs for future planning. Do you have current concerns or anticipate problems in the following areas?

1. Housing or living situation:

2. Food or nutrition:

3. Self-care (grooming, bathing, toileting):

4. Physical health:

5. Household tasks (cooking, medication management, financial affairs):

6. Emotional and mental factors including memory loss:

7. Financial Matters:

8. Day-to-day routines (Socializing, hobbies, church):

9. Transportation:

10. Marital-family relationships:

11. List any other problems which the caregiver/family feel need further investigation: