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Dear [Caregiver]: ____

Your _____________________ is a patient of the Healthy Aging Brain Center. We would appreciate it if you would complete the attached HABC Monitor form. Your answers are important in helping us with the ongoing evaluation and treatment of ______________________. In particular, we appreciate your help in monitoring any changes in your ________________________'s memory, mood, behaviors, and day-to-day activity. We are also concerned about <u>your</u> overall health.

When you are completing this form, please keep in mind the following:

1. Please mark each item based on your first reaction – evidence of actual change is not as important as your gut instinct.

2. There are no formal definitions for the symptoms you are being asked to rate, although, in some cases, examples of the symptom are included. In general, whatever the term means to you is a reasonable and acceptable definition.

3. Rate the frequency of the symptoms over the past two weeks using a scale of:

   - Not at all (0-1 day)
   - Several days (2-6 days)
   - More than half the days (7-11 days)
   - Nearly every day (12 -14 days)

4. What is your date of birth? ______________

5. What is your race? White Black Asian Hispanic Other _____________

6. How many years of education did you complete? ________________

7. How well do you know the patient? ☐ Not at all ☐ Somewhat well ☐ Well ☐ Very well

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If you have any questions, please feel free to contact our care coordinators, Cathy Alder (317-630-7882), Jo Groves (317-630-2519), Lisa Hovious (317-630-6457) or Beth Tobin (317-630-7519). Thank you for your assistance.

Over the past **two weeks**, how often did **your loved one** have problems with: (Use √ to indicate your answer.)	Not at all **(0-1 day)** 0 points	Several Days **(2-6 days)** 1 point	More than half the days (**7-11 days)** 2 points	Almost daily **(12-14 days)** 3 points
Judgment or decision-making				
Repeating the same things over and over such as questions or stories				
Forgetting the correct month or year				
Handling complicated financial affairs such as balancing checkbook, income taxes & paying bills				
Remembering appointments				
Thinking or memory				
Learning how to use a tool, appliance, or gadget				
Planning, preparing, or serving meals				
Taking medications in the right dose at the right time				
Walking or physical ambulation				
Bathing				
Shopping for personal items like groceries				
Housework or household chores				
Leaving her/him alone				
Her/his safety				
Her/his quality of life				
Falling or tripping				
Less interest or pleasure in doing things, hobbies or activities				
Feeling down, depressed, or hopeless				
Being stubborn, agitated, aggressive or resistive to help from others				
Feeling anxious, nervous, tense, fearful or panic				
Believing others are stealing from them or planning to harm them				
Hearing voices, seeing things or talking to people who are not there				
Poor appetite or overeating				
Falling asleep, staying asleep, or sleeping too much				
Acting impulsively, without thinking through the consequences of her/his actions				
Wandering, pacing, or doing things repeatedly				
Over the past **two weeks**, how often did **you** have problems with: (Use √ to indicate your answer.)	Not at all **(0-1 day)** 0 points	Several Days **(2-6 days)** 1 point	More than half the days (**7-11 days)** 2 points	Almost daily **(12-14 days)** 3 points
Your quality of life				
Your financial future				
Your mental health				
Your physical health				

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	COGNITIVE SUBSCALE	
	FUNCTIONAL SUBSCALE	
	BEHAVIORAL AND MOOD SUBSCALE	
	CAREGIVER STRESS SUBSCALE	
	TOTAL SCORE	