



Form B5: BEHAVIORAL ASSESSMENT – Neuropsychiatric Inventory Questionnaire (NPI-Q¹)

In-person Remote Not completed _____

(Reason not completed: 95=Physical problem, 96=Cognitive/behavioral problem, 97=Other, 98=Verbal refusal)

ADRC name: _____ Participant ID: _____ Form date: ____ / ____ / ____

Visit #: _____ Examiner's initials: _____ Language: English Spanish

INSTRUCTIONS: This form is to be completed by the clinician or other trained health professional based on co-participant interview, as described by the training video. (This is not to be completed by the participant as a paper-and-pencil self-report.) For information on NPI-Q Interviewer Certification, see **UDS Coding Guidebook for Initial Visit Packet, Form B5**. Check only one box for each category of response.

Please answer the following questions based on changes that have occurred since the participant first began to experience memory (i.e., cognitive) problems. **Select 1=Yes only if the symptom(s) has been present in the last month. Otherwise, select 0=No.** (NOTE: for the UDS, please administer the NPI-Q to all participants.)

For each item marked **1=Yes**, rate the SEVERITY of the symptom (how it affects the participant):

1= **Mild** (noticeable, but not a significant change) 2= **Moderate** (significant, but not a dramatic change) 3= **Severe** (very marked or prominent; a dramatic change)

1. **NPI CO-PARTICIPANT:** 1 Spouse 2 Child 3 Other (SPECIFY): _____

					SEVERITY			
		Yes	No	Unk	Mild	Mod	Sev	Unk
2.	Delusions – Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?	2a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	2b. <input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
3.	Hallucinations – Does the patient have hallucinations such as false visions or voices? Does he or she seem to hear or see things that are not present?	3a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	3b. <input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
4.	Agitation/Aggression – Is the patient resistive to help from others at times, or hard to handle?	4a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	4b. <input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
5.	Depression/Dysphoria – Does the patient seem sad or say that he/she is depressed?	5a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	5b. <input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
6.	Anxiety – Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?	6a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	6b. <input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
7.	Elation/Euphoria – Does the patient appear to feel too good or act excessively happy?	7a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	7b. <input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
8.	Apathy/Indifference – Does the patient seem less interested in his/her usual activities or in the activities and plans of others?	8a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	8b. <input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
9.	Disinhibition – Does the patient seem to act impulsively, for example, talking to strangers as if he/she knows them, or saying things that may hurt people's feelings?	9a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	9b. <input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
10.	Irritability/Lability – Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?	10a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	10b. <input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
11.	Motor disturbance – Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?	11a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	11b. <input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
12.	Nighttime behaviors – Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?	12a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	12b. <input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
13.	Appetite/Eating – Has the patient lost or gained weight, or had a change in the type of food he/she likes?	13a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	13b. <input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9

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