

INITIAL VISIT PACKET NACC UNIFORM DATA SET (UDS) **LBD MODULE V3.1 SHORT VERSION**

Form B4L: Neuropsychiatric Inventory (NPI)¹

ADC name: _____ Subject ID: _____ Form date: ____ / ____ / _____

Visit #: _____ Examiner's initials: _____

INSTRUCTIONS: This form is to be completed by a clinician or other trained health professional based on co-participant interview. For additional clarification and examples, see LBD Module Coding Guidebook for Initial Visit Packet, Form B4L. Check only one box per question.

Inquire about symptoms the last four weeks before visit.

DELUSIONS			
1.	<p>Does the participant have beliefs that you know are not true (for example, insisting that people are trying to harm him/her or steal from him/her)? Has he/she said that family members are not who they say they are or that the house is not their home? I'm not asking about mere suspiciousness; I am interested if the participant is <u>convinced</u> that these things are happening to him/her.</p> <p><input type="checkbox"/> 0 No (SKIP TO QUESTION 2)</p> <p><input type="checkbox"/> 1 Yes (COMPLETE QUESTIONS 1a – 1i)</p> <p><input type="checkbox"/> 8 Not applicable (SKIP TO QUESTION 2)</p>		
1a.	Does the participant believe that he/she is in danger — that others are planning to hurt him/her?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
1b.	Does the participant believe that others are stealing from him/her?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
1c.	Does the participant believe that his/her spouse is having an affair?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
1d.	Does the participant believe that unwelcome guests are living in his/her house?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
1e.	Does the participant believe that his/her spouse or others are not who they claim to be?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
1f.	Does the participant believe that his/her house is not his/her home?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
1g.	Does the participant believe that family members plan to abandon him/her?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
1h.	Does the participant believe that television or magazine figures are actually present in the home? [Does he/she try to talk or interact with them?]	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
1i.	Does the participant believe any other unusual things that I haven't asked about?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes

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HALLUCINATIONS			
2.	<p>Does the participant have hallucinations such as seeing false visions or hearing imaginary voices? Does he/she seem to see, hear, or experience things that are not present? By this question, we do not mean just mistaken beliefs such as stating that someone who has died is still alive; rather we are asking if the participant actually has abnormal experiences of sounds or visions.</p> <p><input type="checkbox"/> 0 No (SKIP TO QUESTION 3)</p> <p><input type="checkbox"/> 1 Yes (COMPLETE QUESTIONS 2a – 2g)</p> <p><input type="checkbox"/> 8 Not applicable (SKIP TO QUESTION 3)</p>		
2a.	Does the participant describe hearing voices or acts if he/she hears voices?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
2b.	Does the participant talk to people who are not there?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
2c.	Does the participant describe seeing things not seen by others or behave as if he/she is seeing things not seen by others?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
2d.	Does the participant report smelling odors not smelled by others?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
2e.	Does the participant describe feeling things on his/her skin or otherwise appear to be feeling things crawling or touching him/her?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
2f.	Does the participant describe tastes that are without any known cause?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
2g.	Does the participant describe any other unusual sensory experiences?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
ANXIETY			
3.	<p>Is the participant very nervous, worried, or frightened for no apparent reason? Does he/she seem very tense or fidgety? Is the participant afraid to be apart from you?</p> <p><input type="checkbox"/> 0 No (SKIP TO QUESTION 4)</p> <p><input type="checkbox"/> 1 Yes (COMPLETE QUESTIONS 3a – 3g)</p> <p><input type="checkbox"/> 8 Not applicable (SKIP TO QUESTION 4)</p>		
3a.	Does the participant say that he/she is worried about planned events?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
3b.	Does the participant have periods of feeling shaky, unable to relax, or feeling excessively tense?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
3c.	Does the participant have periods of (or complain of) shortness of breath, gasping, or sighing for no apparent reason other than nervousness?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
3d.	Does the participant complain of butterflies in his/her stomach, or of racing or pounding of the heart in association with nervousness (symptoms not explained by ill health)?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
3e.	Does the participant avoid certain places or situations that make him/her more nervous such as riding in the car, meeting with friends, or being in crowds?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
3f.	Does the participant become nervous and upset when separated from you [or his/her caregiver]? [Does he/she cling to you to keep from being separated?]	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
3g.	Does the participant show any other signs of anxiety?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes

APATHY / INDIFFERENCE			
4.	<p>Has the participant lost interest in the world around him/her? Has he/she lost interest in doing things or lack motivation for starting new activities? Is he/she more difficult to engage in conversation or in doing chores? Is the participant apathetic or indifferent?</p> <p><input type="checkbox"/> 0 No (END FORM HERE)</p> <p><input type="checkbox"/> 1 Yes (COMPLETE QUESTIONS 4a – 4h)</p> <p><input type="checkbox"/> 8 Not applicable (END FORM HERE)</p>		
4a.	Does the participant seem less spontaneous and less active than usual?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
4b.	Is the participant less likely to initiate a conversation?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
4c.	Is the participant less affectionate or lacking in emotions when compared to his/her usual self?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
4d.	Does the participant contribute less to household chores?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
4e.	Does the participant seem less interested in the activities and plans of others?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
4f.	Has the participant lost interest in friends and family members?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
4g.	Is the participant less enthusiastic about his/her usual interests?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes
4h.	Does the participant show any other signs that he/she doesn't care about doing new things?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes