

NACC Uniform Data Set (UDS) Follow-up Form B5: Behavioral Assessment – Neuropsychiatric Inventory Questionnaire (NPI-Q¹)

Center: _____ ADC Subject ID: _____ Form Date: ___/___/____ ADC Visit #: _____

NOTE: This form is to be completed by the clinician or other trained health professional per informant interview, as described by the training video. (This is not to be completed by the subject as a paper-and-pencil self-report.) For information regarding NPI-Q Interviewer Certification, see UDS Coding Guidebook for Follow-up Visit Packet, Form B5. Check only one box for each category of response. Examiner's initials: _____

Please ask the following questions based upon changes. Indicate "yes" only if the symptom has been present in the past month; otherwise, indicate "no".
 For each item marked "yes", rate the SEVERITY of the symptom (how it affects the patient):
 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)

		Yes	No		Severity
1. NPI informant: <input type="checkbox"/> 1 Spouse <input type="checkbox"/> 2 Child <input type="checkbox"/> 3 Other (<i>specify</i>): _____					
2. DELUSIONS: Does the patient believe that others are stealing from him or her, or planning to harm him or her in some way?	2a.	<input type="checkbox"/> 1	<input type="checkbox"/> 0		2b. <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
3. HALLUCINATIONS: Does the patient act as if he or she hears voices? Does he or she talk to people who are not there?	3a.	<input type="checkbox"/> 1	<input type="checkbox"/> 0		3b. <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
4. AGITATION OR AGGRESSION: Is the patient stubborn and resistive to help from others?	4a.	<input type="checkbox"/> 1	<input type="checkbox"/> 0		4b. <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
5. DEPRESSION OR DYSPHORIA: Does the patient act as if he or she is sad or in low spirits? Does he or she cry?	5a.	<input type="checkbox"/> 1	<input type="checkbox"/> 0		5b. <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
6. ANXIETY: Does the patient become upset when separated from you? Does he or 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		6b. <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

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7. ELATION OR EUPHORIA: Does the patient appear to feel too good or act excessively happy?	7a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	7b. <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
8. APATHY OR INDIFFERENCE: Does the patient seem less interested in his or her usual activities and in the activities and plans of others?	8a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	8b. <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
9. DISINHIBITION: Does the patient seem to act impulsively? For example, does the patient talk to strangers as if he or she knows them, or does the patient say things that may hurt people's feelings?	9a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	9b. <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
10. IRRITABILITY OR LABILITY: Is the patient impatient or cranky? Does he or she have difficulty coping with delays or waiting for planned activities?	10a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	10b. <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
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	11b. <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
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	12b. <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
13. APPETITE AND EATING: Has the patient lost or gained weight, or had a change in the food he or she likes?	13a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	13b. <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3