



## NACC Uniform Data Set (UDS) Follow-up Form B9: Clinician Judgment of Symptoms

Center: \_\_\_\_\_ ADC Subject ID: \_\_\_\_\_ Form Date: \_\_\_/\_\_\_/\_\_\_

**NOTE: This form is to be completed by the clinician. For additional clarification and examples, see UDS Coding Guidebook for Follow-up Visit Packet, Form B9. Check only one box per question.**

ADC Visit #: \_\_\_\_\_

Examiner's initials: \_\_\_\_\_

MEMORY COMPLAINT/AGE OF ONSET:	Yes	No
Relative to previously attained abilities:		
1. Does the subject report a decline in memory?	<input type="checkbox"/> 1	<input type="checkbox"/> 0
2. Does the informant report a decline in subject's memory?	<input type="checkbox"/> 1	<input type="checkbox"/> 0
3a. Does the clinician believe there has been a current meaningful decline in the subject's memory, non-memory cognitive abilities, behavior, or ability to manage his/her affairs, or have there been motor/movement changes?	<input type="checkbox"/> 1	<input type="checkbox"/> 0
<i>(If no, end form here)</i>		
3b. At what age did the cognitive decline begin (based upon the clinician's assessment)?	_____ (999 = Unknown) (888 = N/A)	

COGNITIVE SYMPTOMS:	Yes	No	Unknown
4. Indicate whether the subject currently is impaired meaningfully, relative to previously attained abilities, in the following cognitive domains or has fluctuating cognition:			
a. <b>Memory</b> (For example, does s/he forget conversations and/or dates; repeat questions and/or statements; misplace more than usual; forget names of people s/he knows well?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
b. <b>Judgment and problem-solving</b> (For example, does s/he have trouble handling money (tips); paying bills; shopping; preparing meals; handling appliances; handling medications; driving?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
c. <b>Language</b> (For example, does s/he have hesitant speech; have trouble finding words; use inappropriate words without self-correction?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
d. <b>Visuospatial function</b> (Difficulty interpreting visual stimuli and finding his/her way around.)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
e. <b>Attention/concentration</b> (For example, does the subject have a short attention span or ability to concentrate? Is s/he easily distracted?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
f. <b>Fluctuating cognition</b> (Does s/he have pronounced variation in attention and alertness, noticeably over hours or days? For example, long periods of staring into space or lapses, or times when his/her ideas have a disorganized flow.)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
g. <b>Other</b> (If yes, then specify): _____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
<i>(continued on next page)</i>			

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5. Indicate the <u>predominant</u> symptom which was first recognized as a decline in the subject's cognition:	<input type="checkbox"/> 1 Memory	<input type="checkbox"/> 6 Other ( <i>specify</i> ): _____
	<input type="checkbox"/> 2 Judgment and problem solving	<input type="checkbox"/> 7 Fluctuating cognition
	<input type="checkbox"/> 3 Language	<input type="checkbox"/> 88 N/A
	<input type="checkbox"/> 4 Visuospatial function	<input type="checkbox"/> 99 Unknown
	<input type="checkbox"/> 5 Attention/concentration	
6. Mode of onset of cognitive symptoms:	<input type="checkbox"/> 1 Gradual (> 6 months)	<input type="checkbox"/> 4 Other ( <i>specify</i> ): _____
	<input type="checkbox"/> 2 Subacute (≤ 6 months)	<input type="checkbox"/> 88 N/A
	<input type="checkbox"/> 3 Abrupt ( <i>within days</i> )	<input type="checkbox"/> 99 Unknown

<b>BEHAVIOR SYMPTOMS:</b>	<b>Yes</b>	<b>No</b>	<b>Unknown</b>
7. Indicate whether the subject currently manifests the following behavioral symptoms:			
a. <b>Apathy/withdrawal</b> (Has the subject lost interest in or displayed a reduced ability to initiate usual activities and social interaction, such as conversing with family and/or friends?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
b. <b>Depression</b> (Has the subject seemed depressed for more than two weeks at a time; e.g., loss of interest or pleasure in nearly all activities; sadness, hopelessness, loss of appetite, fatigue?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
c. <b>Psychosis</b>			
1) Visual hallucinations	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
a) If yes, are the hallucinations well-formed and detailed?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
2) Auditory hallucinations	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
3) Abnormal/false/delusional beliefs	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
d. <b>Disinhibition</b> (Does the subject use inappropriate coarse language or exhibit inappropriate speech or behaviors in public or in the home? Does s/he talk personally to strangers or have disregard for personal hygiene?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
e. <b>Irritability</b> (Does the subject overreact, such as shouting at family members or others?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
f. <b>Agitation</b> (Does the subject have trouble sitting still; does s/he shout, hit, and/or kick?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
g. <b>Personality change</b> (Does the subject exhibit bizarre behavior or behavior uncharacteristic of the subject, such as unusual collecting, suspiciousness [without delusions], unusual dress, or dietary changes? Does the subject fail to take other's feelings into account?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
h. <b>REM sleep behavior disorder</b> (Does the subject appear to act out his/her dreams while sleeping (e.g., punch or flail their arms, shout or scream?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
i. <b>Other</b> ( <i>If yes, then specify</i> ): _____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9

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8. Indicate the <u>predominant</u> symptom which was first recognized as a decline in the subject's behavioral symptoms:	<input type="checkbox"/> 1 Apathy/withdrawal <input type="checkbox"/> 2 Depression <input type="checkbox"/> 3 Psychosis <input type="checkbox"/> 4 Disinhibition <input type="checkbox"/> 5 Irritability <input type="checkbox"/> 6 Agitation	<input type="checkbox"/> 7 Personality change <input type="checkbox"/> 8 Other ( <i>specify</i> ): _____ <input type="checkbox"/> 9 REM sleep behavior disorder <input type="checkbox"/> 88 N/A <input type="checkbox"/> 99 Unknown
9. Mode of onset of behavioral symptoms:	<input type="checkbox"/> 1 Gradual (> 6 months) <input type="checkbox"/> 2 Subacute (≤ 6 months) <input type="checkbox"/> 3 Abrupt ( <i>within days</i> )	<input type="checkbox"/> 4 Other ( <i>specify</i> ): _____ <input type="checkbox"/> 88 N/A <input type="checkbox"/> 99 Unknown

MOTOR SYMPTOMS:	Yes	No	Unknown
10. Indicate whether the subject currently has the following motor symptoms:			
a. <b>Gait disorder</b> (Has the subject's walking changed, not specifically due to arthritis or an injury? Is s/he unsteady, or does s/he shuffle when walking, have little or no arm-swing, or drag a foot?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
b. <b>Falls</b> (Does the subject fall more than usual?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
c. <b>Tremor</b> (Has the subject had rhythmic shaking, especially in the hands, arms, legs, head, mouth, or tongue?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
d. <b>Slowness</b> (Has the subject noticeably slowed down in walking or moving or handwriting, other than due to an injury or illness? Has his/her facial expression changed, or become more "wooden" or masked and unexpressive?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
11. Indicate the <u>predominant</u> symptom which was first recognized as a decline in the subject's motor symptoms:	<input type="checkbox"/> 1 Gait disorder <input type="checkbox"/> 2 Falls <input type="checkbox"/> 3 Tremor	<input type="checkbox"/> 4 Slowness <input type="checkbox"/> 88 N/A <input type="checkbox"/> 99 Unknown	
12. Mode of onset of motor symptoms:	<input type="checkbox"/> 1 Gradual (> 6 months) <input type="checkbox"/> 2 Subacute (≤ 6 months) <input type="checkbox"/> 3 Abrupt ( <i>within days</i> )	<input type="checkbox"/> 4 Other ( <i>specify</i> ): _____ <input type="checkbox"/> 88 N/A <input type="checkbox"/> 99 Unknown	
a. If there were changes in motor function, were these suggestive of parkinsonism?	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 88 N/A		

OVERALL SUMMARY OF SYMPTOMS ONSET:			
13. Course of overall cognitive/behavioral/motor syndrome:	<input type="checkbox"/> 1 Gradually progressive <input type="checkbox"/> 2 Stepwise <input type="checkbox"/> 3 Static	<input type="checkbox"/> 4 Fluctuating <input type="checkbox"/> 5 Improved <input type="checkbox"/> 9 Unknown	
14. Indicate the <u>predominant</u> domain which was first recognized as changed in the subject:	<input type="checkbox"/> 1 Cognition <input type="checkbox"/> 2 Behavior	<input type="checkbox"/> 3 Motor function <input type="checkbox"/> 9 Unknown	