

INITIAL VISIT PACKET NACC UNIFORM DATA SET (UDS)

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

ADC name: _____ Subject ID: _____ Form date: ____/____/____ Visit #: _____ Examiner's initials: _____

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 subject 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.

CORRECTED INSTRUCTIONS: Please answer the following questions based on changes that have occurred since the patient 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 subjects.)

For each item marked **1=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)

					SEVERITY				
		Yes	No	Unknown	Mild	Mod	Severe	Unknown	
1. NPI CO-PARTICIPANT: <input type="checkbox"/> 1 Spouse <input type="checkbox"/> 2 Child <input type="checkbox"/> 3 Other (SPECIFY): _____									
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

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					SEVERITY				
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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