

ADULT QUESTIONNAIRE RELATIVE FORM

Confidential

TO BE COMPLETED BY RELATIVE: Information requested on this questionnaire will aid us in understanding your family member's problems. We would appreciate you filling it out carefully and fully. Please feel free to add as much information as you want. You may use the backs of pages if necessary.

Patient Name _____

Relative/ Friend Name _____ Date _____

Address _____
(street) (city/state) (zip)

Home phone # _____ Business Phone # _____

In this section, please describe your relative in regard to each of the following aspects of mental functioning behavior. Describe the situation before the accident or illness on the left and the recent or current on condition on the right. *If the condition is one that the patient has experienced all of his or her life, then only complete the column on the left side of the page.*

Before the accident or illness

Recently and currently

Concentration

Energy and activity level

Depression

Elation and other types of high mood

Sleep

Anger or Anger Control Problems

Before the accident or illness

Recently and currently

Agitation or Irritability

Appetite for food

Sexual behavior and sexual interest

Consumption of alcohol and other drugs

Hearing

Vision and other aspects of sight

Ability to find their way around - Spatial ability

Headaches

Pains other than in the head

Fatigue

Understanding what is heard

Finding words when trying to talk in conversation

Before the accident or illness

Recently and currently

Memory for things people say or things need to do

Imagery and memory for faces

Reading

Calculating - balancing check book

Playing or listening to music

Motor behavior - skillful activity

Unusual sensations or strange experiences

Ability to relax and experience pleasure

Social behavior - being with people

Ability to work or hold job

Please use this space for additional information which you think would be helpful:

(signature)

(date)