

Brain Health Assessment

PATIENT INFORMATION

Name: _____ Age: _____

Gender:

Male Female Other

Date of Birth: _____ dd / mm / yyyy Occupation: _____

Referring Physician: _____ Date of Assessment: _____ dd / mm / yyyy

ASSESSMENT

1. I have difficulty remembering new information (names, events, etc.).

1 2 3 4 5

2. I have difficulty recalling past events or information.

1 2 3 4 5

3. I find it hard to focus on tasks or maintain attention during conversations.

1 2 3 4 5

4. I am easily distracted.

1 2 3 4 5

5. I face challenges in planning and organizing tasks.

1 2 3 4 5

6. Making decisions or solving problems is challenging for me.

1 2 3 4 5

7. I struggle to find the right words or follow conversations.

1 2 3 4 5

8. Expressing my thoughts verbally or in writing is challenging.

1 2 3 4 5

9. I have experienced significant changes in my mood (e.g., sadness, anxiety).

1 2 3 4 5

10. I have noticed changes in my behavior or personality.

1 2 3 4 5

11. I have lost interest in activities or hobbies I used to enjoy.

1 2 3 4 5

12. My sleep patterns are irregular (difficulty falling or staying asleep).

1 2 3 4 5

13. I feel rested and rejuvenated after a night's sleep.

1 2 3 4 5

14. I have healthy eating habits and regularly consume a balanced diet.

1 2 3 4 5

15. I consume alcohol or use tobacco products.

1 2 3 4 5

16. I engage in activities that challenge my brain, such as puzzles, reading, or learning new skills.

1 2 3 4 5

17. I engage in regular physical exercise (e.g., walking, cycling, gym workouts).

1 2 3 4 5

18. I participate in social activities and maintain regular contact with friends and family.

1 2 3 4 5

Patient History:

Additional Notes: