Healthy Aging Brain Care (HABC) Monitor – Self Report Version

Dear [Patient]: _____

We would appreciate it if you would complete the attached HABC Monitor form. Your answers are important in helping us with the ongoing evaluation and treatment of your brain health. In particular, we appreciate your help in monitoring any changes in your memory, mood, behaviors, and day-to-day activity. We are also interested in your overall health.

When you are completing this form, please keep in mind the following:

1. Please mark each item based on your first reaction – evidence of actual change is not as important as your gut instinct.

2. Rate the frequency of the symptoms over the past two weeks using a scale of:

    - Not at all (0-1 day)
    - Several days (2-6 days)
    - More than half the days (7-11 days)
    - Nearly every day (12 -14 days)

3. What is your date of birth? _____

4. What is your race? White Black Asian Hispanic Other _____

5. How many years of education did you complete? _____

6. How well do you know the patient? ☐ Not at all ☐ Somewhat well ☐ Well ☐ Very well

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If you have any questions, please feel free to contact any of our care coordinators at the following numbers:

Lisa Hovious, RN	880-6611
Kristine Matel, MSW, LSW	880-6617
Cynthia Reynolds, MSW, LCSW	880-6618

Thank you for your assistance.

Over the past **two weeks**, how often did **you** have problems with: (Use √ to indicate your answer.)	Not at all (**0-1 day**) 0 points	Several Days (**2-6 days**) 1 point	More than half the days (**7-11 days**) 2 points	Almost daily (**12-14 days**) 3 points
Judgment or decision-making				
Repeating the same things over and over such as questions or stories				
Forgetting the correct month or year				
Handling complicated financial affairs such as balancing checkbook, income taxes & paying bills				
Remembering appointments				
Thinking or memory				
Learning how to use a tool, appliance or gadget				
Planning, preparing, or serving meals				
Taking medications in the right dose at the right				
Walking or physical ambulation				
Bathing				
Shopping for personal items like groceries				
Housework or household chores				
Your safety				
Your quality of life				
Falling or tripping				
Less interest or pleasure in doing things, hobbies or activities				
Feeling down, depressed, or hopeless				
Resisting help from others or getting agitated				
Feeling anxious, nervous, tense, fearful or panic				
Believing others are stealing from you or planning to harm you				
Hearing voices, seeing things or talking to people who are not there				
Poor appetite or overeating				
Falling asleep, staying asleep, or sleeping too much				
Acting impulsively, without thinking through the consequences of your actions				
Wandering, pacing, or doing things repeatedly				

Place Sticker Here		
	COGNITIVE SUBSCALE	
	FUNCTIONAL SUBSCALE	
	BEHAVIORAL AND MOOD SUBSCALE	
	TOTAL SCORE	