

## THE NEUROPSYCHIATRIC INVENTORY–QUESTIONNAIRE

Please answer the following questions based on changes that have occurred since the patient first began to experience memory problems.

Circle "Yes" only if the symptom(s) has been present in the last month. Otherwise, circle "No". For each item marked "Yes":

**a) 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)

**b) Rate the DISTRESS you experience due to that symptom (how it affects you):**

**0 = Not distressing at all**

**1 = Minimal** (slightly distressing, not a problem to cope with)

**2 = Mild** (not very distressing, generally easy to cope with)

**3 = Moderate** (fairly distressing, not always easy to cope with)

**4 = Severe** (very distressing, difficult to cope with)

**5 = Extreme or Very Severe** (extremely distressing, unable to cope with)

**Note: If there is NO caretaker then only fill out the SEVERITY questions.**

Please answer each question carefully. Ask for assistance if you have any questions.

	Present	Severity	Distress
<b>Delusions</b>			
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?	Yes / No	1 2 3	0 1 2 3 4 5
<b>Hallucinations</b>			
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?	Yes / No	1 2 3	0 1 2 3 4 5
<b>Agitation/Aggression</b>			
Is the patient resistive to help from others at times, or hard to handle?	Yes / No	1 2 3	0 1 2 3 4 5
<b>Depression/Dysphoria</b>			
Does the patient seem sad or say that he /she is depressed?	Yes / No	1 2 3	0 1 2 3 4 5
<b>Anxiety</b>			
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?	Yes / No	1 2 3	0 1 2 3 4 5
<b>Elation/Euphoria</b>			
Does the patient appear to feel too good or act excessively happy?	Yes / No	1 2 3	0 1 2 3 4 5

**Apathy/Indifference**

Does the patient seem less interested in his/her usual activities or in the activities and plans of others?

Yes / No      1   2   3      0 1 2 3 4 5

**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?

Yes / No      1   2   3      0 1 2 3 4 5

**Irritability/Lability**

Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?

Yes / No      1   2   3      0 1 2 3 4 5

**Motor Disturbance**

Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?

Yes / No      1   2   3      0 1 2 3 4 5

**Nighttime Behaviors**

Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?

Yes / No      1   2   3      0 1 2 3 4 5

**Appetite/Eating**

Has the patient lost or gained weight, or had a change in the type of food he/she likes?

Yes / No      1   2   3      0 1 2 3 4 5