*brain*Health Manchester Pre-Assessment

Patient Booklet

Your assessment at *brain*HEALTH Manchester will involve some pen and paper testing and a brief physical examination. To speed up your assessment we ask you to complete the questionnaires in this booklet and bring the whole booklet with you to your appointment. Keep it somewhere safe between now and the day of your appointment.

Please print your name here: _____

Thank you!

Dr. Ross Dunne,

Consultant, *brain*HEALTH Manchester

Name:_____ Date: _____

Pittsburgh Sleep Quality Index (PSQI)

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. **Please answer all questions.**

1. During the past month, what time have you usually gone to bed at night? _____
2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night? _____
3. During the past month, what time have you usually gotten up in the morning? _____
4. During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.) _____

5. During the past month, how often have you had trouble sleeping because you…	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
a. Cannot get to sleep within 30 minutes				
b. Wake up in the middle of the night or early morning				
c. Have to get up to use the bathroom				
d. Cannot breathe comfortably				
e. Cough or snore loudly				
f. Feel too cold				
g. Feel too hot				
h. Have bad dreams				
i. Have pain				
j. Other reason(s), please describe:				
6. During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")?				
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?				
	No problem at all	Only a very slight problem	Somewhat of a problem	A very big problem
8. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?				
	Very good	Fairly good	Fairly bad	Very bad
9. During the past month, how would you rate your sleep quality overall?				

	No bed partner or room mate	Partner/room mate in other room	Partner in same room but not same bed	Partner in same bed
10. Do you have a bed partner or room mate?				
	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
If you have a room mate or bed partner, ask him/her how often in the past month you have had:				
a. Loud snoring				
b. Long pauses between breaths while asleep				
c. Legs twitching or jerking while you sleep				
d. Episodes of disorientation or confusion during sleep				
e. Other restlessness while you sleep, please describe:				

Epworth Sleepiness Scale

Name: _____

Date: _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:-

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	**Chance of dozing**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total	

Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ = *Total score* _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Depression

1	Are you basically satisfied with your life?	**No** Yes
2	Have you dropped many of your activities or interests?	**Yes** No
3	Do you feel that your life is empty?	**Yes** No
4	Do you often feel bored?	**Yes** No
5	Are you in good spirits most of the time?	**No** Yes
6	Are you afraid that something bad is going to happen to you?	**Yes** No
7	Do you feel happy most of the time?	**No** Yes
8	Do you often feel helpless?	**Yes** No
9	Do you prefer to stay at home, rather than going out and doing new things?	**Yes** No
10	Do you feel you have more problems with your memory than most?	**Yes** No
11	Do you think it is wonderful to be alive?	**No** Yes
12	Do you feel pretty worthless the way you are now	**Yes** No
13	Do you feel full of energy?	**No** Yes
14	Do you feel that your situation is hopeless?	**Yes** No
15	Do you think that most people are better off than you are?	**Yes** No
	> **TOTAL:**	

MEDITERRANEAN DIET SCORE TOOL

A Mediterranean dietary pattern ('Med diet') is typically one based on whole or minimally processed foods. It's rich in protective foods (fruits, vegetables, legumes, wholegrains, fish and olive oil) and low in adverse dietary factors (fast food, sugar-sweetened beverages, refined grain products and processed or energy-dense foods) with moderate red meat and alcohol intake.

Evidence shows **overall dietary pattern** (reflected in TOTAL SCORE) as well as **individual components** reflect risk; a higher score is associated with lower risk of CVD and all-cause mortality (BMJ 2008;337:a1344). During rehabilitation patient scores should ideally rise in response to dietary advice and support.

This tool can be used by health professionals with appropriate nutritional knowledge and competencies, such as Registered Dietitians (NICE, 2007, 2013). It can be used as both an *audit tool* and *as part of a dietary assessment* at baseline, end of programme and 1 year follow-up, along with assessment and advice for weight management, salt intake and eating behaviours. For information on complete requirements for dietary assessments and advice, please refer to the latest NICE/Joint British Societies guidelines (BACPR, 2012. The BACPR Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation, 2nd Ed.).

	Question	Yes	No	Nutritional issue to discuss in response
1.	Is olive oil the main culinary fat used?			**Choosing Healthier Fats** Olive oil is high in monounsaturated fat. Using unsaturated fats instead of saturated fats in cooking and preparing food is advisable.
2.	Are ≥ 4 tablespoons of olive oil used each day?			**Healthy fats are better than very low fat** Med diet is more beneficial than a very low fat diet in prevention of CVD. So replacing saturated with unsaturated fat is better than replacing it with carbohydrates or protein.
3.	Are ≥ 2 servings (of 200g each) of vegetables eaten each day?			**Eat plenty of fruits and vegetables** Eating a wide variety of fruit and vegetables every day helps ensure adequate intake of many vitamins, minerals, phytochemicals and fibre. Studies have shown that eating plenty of these foods is protective for CVD and cancer.
4.	Are ≥ 3 servings of fruit (of 80g each) eaten each day?			
5.	Is < 1 serving (100-150g) of red meat/ hamburgers/ other meat products eaten each day?			**Choose lean meats and consider cooking methods** Red and processed meats are high in saturated fat, can be high in salt and are best replaced with white meat or fish or vegetarian sources of protein. Grill or roast without fat, casserole or stir fry.
6.	Is < 1 serving (12g) of butter, margarine or cream eaten each day?			**Keep saturated fat low** These foods are high in saturated fat which can increase your blood cholesterol level. Choose plant-based or reduced-fat alternatives.
7.	Is < 1 serving (330ml) of sweet or sugar sweetened carbonated beverages consumed each day?			Excessive consumption of sugar-sweetened beverages can worsen many risk factors for CVD: keep consumption to < 1/day.
8.	Are ≥ 3 glasses (of 125ml) of wine consumed each week?			**Moderate alcohol intake with meals** While this does have some protective effect but ***there is no evidence that non-drinkers should take up drinking alcohol*.**
9.	Are ≥ 3 servings (of 150g) of legumes consumed each week?			**Include soluble fibre** These foods are high in soluble fibre and other useful nutrients. Regular consumption is advisable for raised cholesterol.
10.	Are ≥ 3 servings of fish (100-150g) or seafood (200g) eaten each week?			**Eat more oily and white fish** Oily fish is an excellent source of essential omega-3 fats. White fish is very low in saturated fat.
11.	Is < 3 servings of commercial sweets/pastries eaten each week?			**Eat less processed food** These foods are usually high in saturated fat, salt or sugar and often contain trans fats. Replacing these with healthy snacks such as fruit or unsalted nuts is beneficial.
12.	Is ≥ 1 serving (of 30g) of nuts consumed each week?			**Snack on modest servings of unsalted nuts** Nuts are rich in unsaturated fat, phytosterols, fibre, vitamin E and iron, **e.g. walnuts, almonds, hazelnuts**
13.	Is chicken, turkey or rabbit routinely eaten instead of veal, pork, hamburger or sausage?			'White meat' choices are lower in saturated fat. Remove the skin and consider your cooking method.
14.	Are pasta, vegetable or rice dishes flavoured with garlic, tomato, leek or onion eaten ≥ twice a week?			Using a tomato and garlic or onion or leek-based sauce regularly is a key feature of the Med diet.
TOTAL SCORE (total no. of 'yes' answers)				

Alison Hornby, Katherine Paterson

Alcohol use disorders identification test (AUDIT)

AUDIT is a comprehensive 10 question alcohol harm screening tool. It was developed by the World Health Organisation (WHO) and modified for use in the UK and has been used in a variety of health and social care settings. **Please circle the box that applies to you in each row:**

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 times or more per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Total AUDIT score	

CASP19 Quality of Life Scale (ELSA version)

Please circle the number that corresponds with how much you agree with the phrase

Item no	Sub-domain item no		Often	Sometimes	Not often	Never
1	C1	My age prevents me from doing the things I would like to	0	1	2	3
2	C2	I feel that what happens to me Is out of my control	0	1	2	3
3	C3	I feel free to plan for the future	3	2	1	0
4	C4	I feel left out of things	0	1	2	3
5	A1	I can do the things that I want to do	3	2	1	0
6	A2	Family responsibilities prevent me from doing what I want to do I	0	1	2	3
7	A3	feel that I can please myself what I do	3	2	1	0
8	A4	My health stops me from doing things I want to do	0	1	2	3
9	A5	Shortage of money stops me from doing the things I want to do I	0	1	2	3
10	P1	look forward to each day	3	2	1	0
11	P2	I feel that my life has meaning	3	2	1	0
12	P3	I enjoy the things that I do	3	2	1	0
13	P4	I enjoy being in the company of others	3	2	1	0
14	P5	On balance, I look back on my fife with a sense of happiness	3	2	1	0
15	SR1	I feel full of energy these days	3	2	1	0
16	SR2	I choose to do things that I have never done before	3	2	1	0
17	SR3	I feel satisfied with the way my life has turned out	3	2	1	0
18	SR4	I feel that life is full of opportunities	3	2	1	0
19	SRS	I feel that the future looks good for me	3	2	1	0

Your ears and hearing

How long have you had a problem with your hearing?

Which ear(s) does your hearing problem affect?

Please click 'Yes' or 'No' for each question.

Have you had any sudden or rapid changes in your hearing (within 90 days)?	Yes ◯	No ◯
Does your hearing change on different days?	Yes ◯	No ◯
Do you get pain in your ears?	Yes ◯	No ◯
Do you get any infections or discharge from your ears (not including wax)?	Yes ◯	No ◯
Have you had any ear-related operations?	Yes ◯	No ◯
Have you ever had a perforated eardrum?	Yes ◯	No ◯
Do you hear any rushing, hissing, ringing, beating, pulsing or any other noises in your ears, often called tinnitus?	Yes ◯	No ◯
Do you have a strong sensitivity to everyday loud sounds that do not bother other people?	Yes ◯	No ◯

If you have answered 'Yes' to any of these please give more information:

Have you ever seen an Ear, Nose and Throat specialist for ear, hearing or dizziness problems?

If yes, what was the outcome of this appointment?

Do you wear hearing aids?

If yes, do you experience any problems with your hearing aids?

If no, would you want to hearing aids if they may help you to hear better?

Hearing difficulties

Please click the boxes to select any the situations in which you may find that your hearing affects you. If you feel no situations apply please leave this section blank.

1.	One to one conversation in quiet.	☐
2.	One to one conversation in noise.	☐
3.	Conversations in a group with no background noise.	☐
4.	Conversation in a group with background noise.	☐
5.	Hearing the television or radio at normal volume.	☐
6.	Hearing a familiar speaker on the telephone.	☐
7.	Hearing an unfamiliar speaker on the telephone.	☐
8.	Hearing the phone ring from another room.	☐
9.	Hearing the doorbell or knocker.	☐
10.	Hearing in church or in a meeting	☐
11.	Hearing traffic.	☐
12.	Hearing the fire alarm.	☐
13.	Decreased social contact.	☐
14.	Feeling embarrassed or stupid.	☐
15.	Feeling left out.	☐
16.	Feeling upset or angry.	☐
17.	Other:	☐

Of the situations you ticked, which 3 are most affected by your hearing?
Please enter the numbers that apply here.

*brain*Health Manchester Pre-Assessment

Friend or relative booklet

Your friend or relative is having an assessment at *brain*HEALTH Manchester which will involve some pen and paper testing and a brief physical examination. To speed up their assessment we ask you to complete the brief questionnaires in this booklet and bring the whole booklet with you when you accompany your friend or relative to your appointment. Keep it somewhere safe between now and the day of their appointment.

Your name _____

Your friend or relative's name _____

What is your relationship to the patient? _____

Thank you!

Dr. Ross Dunne,

Consultant, *brain*HEALTH Manchester

Mild Behavioural Impairment Checklist (MBI-C)

ID Number: _____

Interest, motivation, and drive	**None**	**Mild**	**Moderate**	**Severe**
Does the person lack curiosity in topics that would usually have attracted her/his interest?	☐	☐	☐	☐
Has the person lost interest in friends, family, or home activities?	☐	☐	☐	☐
Has the person become less spontaneous and active - for example, is she/he less likely to initiate or maintain conversation?	☐	☐	☐	☐
Has the person lost the motivation to act on their obligations or interests?	☐	☐	☐	☐
Is the person less affectionate and/or lacking in emotions when compared to her/his usual self?	☐	☐	☐	☐
Mood or anxiety symptoms	**None**	**Mild**	**Moderate**	**Severe**
Has the person developed sadness or appear to be in low spirits? Does she/she have episodes of tearfulness?	☐	☐	☐	☐
Has the person become less able to experience pleasure?	☐	☐	☐	☐
Has become discouraged about their future or feel that he/she is a failure?	☐	☐	☐	☐
Does the person view herself/himself as a burden to family?	☐	☐	☐	☐
Has the person become more anxious or worried about things that are routine (e.g. events, visits, etc.)?	☐	☐	☐	☐
Does the person feel very tense, having developed an inability to relax, or shakiness, or symptoms of panic?	☐	☐	☐	☐
Delayed gratification and control behavior, impulses, oral intake and/or changes in reward	**None**	**Mild**	**Moderate**	**Severe**
Has the person become agitated, aggressive, irritable, or temperamental?	☐	☐	☐	☐
Has she/he become unreasonably or uncharacteristically argumentative?	☐	☐	☐	☐
Has the person become more impulsive, seeming to act without considering things?	☐	☐	☐	☐
Does the person display sexually disinhibited or intrusive behaviour, such as touching (themselves/others), hugging, groping, etc., in a manner that is out of character or may cause offence?	☐	☐	☐	☐
Has the person become more easily frustrated or impatient? Does she/he have troubles coping with delays, or waiting for events or for their turn?	☐	☐	☐	☐
Does the person display a new recklessness or lack of judgement when driving (e.g. speeding, erratic swerving, abrupt lane changes, etc.)?	☐	☐	☐	☐
Has the person become more stubborn or rigid, i.e., uncharacteristically insistent on having their way, or unwilling/unable to see/hear other views?	☐	☐	☐	☐

Modified from J Alzheimers Dis. 2017 ; 56(3): 929–938. doi:10.3233/JAD-160979.

Mild Behavioural Impairment Checklist (MBI-C)

ID Number: _____

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Delayed gratification and control behavior, impulses, oral intake and/or changes in reward (continued)	**None**	**Mild**	**Moderate**	**Severe**
Is there a change in eating behaviours (e.g., overeating, cramming the mouth, insistent on eating only specific foods, or eating the food in exactly the same order)?	☐	☐	☐	☐
Does the person no longer find food tasteful or enjoyable? Are they eating less?	☐	☐	☐	☐
Does the person hoard objects when she/he did not do so before?	☐	☐	☐	☐
Has the person developed simple repetitive behaviours or compulsions?	☐	☐	☐	☐
Has the person recently developed trouble regulating smoking, alcohol, drug intake or gambling, or started shoplifting?	☐	☐	☐	☐
Does the person no longer find food tasteful or enjoyable? Are they eating less?	☐	☐	☐	☐
Societal norms and having social graces, tact, and empathy	**None**	**Mild**	**Moderate**	**Severe**
Has the person become less concerned about how her/his words or actions affect others? Has she/he become insensitive to others' feelings?	☐	☐	☐	☐
Has the person started talking openly about very personal or private matters not usually discussed in public?	☐	☐	☐	☐
Does the person say rude or crude things or make lewd sexual remarks that she/he would not have said before?	☐	☐	☐	☐
Does the person seem to lack the social judgement she/he previously had about what to say or how to behave in public or private?	☐	☐	☐	☐
Does the person now talk to strangers as if familiar, or intrude on their activities?	☐	☐	☐	☐
Strongly held beliefs and sensory experiences	**None**	**Mild**	**Moderate**	**Severe**
Has the person developed beliefs that they are in danger, or that others are planning to harm them or steal their belongings?	☐	☐	☐	☐
Has the person developed suspiciousness about the intentions or motives of other people?	☐	☐	☐	☐
Does she/he have unrealistic beliefs about her/his power, wealth or skills?	☐	☐	☐	☐
Does the person describe hearing voices or does she/he talk to imaginary people or "spirits"?	☐	☐	☐	☐
Does the person report or complain about, or act as if seeing things (e.g. people, animals or insects) that are not there, i.e., that are imaginary to others?	☐	☐	☐	☐

Modified from J Alzheimers Dis. 2017 ; 56(3): 929–938. doi:10.3233/JAD-160979.

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)

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

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?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

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?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Agitation/Aggression Is the patient resistive to help from others at times, or hard to handle?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Depression/Dysphoria Does the patient seem sad or say that he /she is depressed?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Anxiety Does the patient become upset when separated from you? Doeshe/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Elation/Euphoria Does the patient appear to feel too good or act excessively happy?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 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 **SEVERITY: 1 2 3** **DISTRESS: 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 **SEVERITY: 1 2 3** **DISTRESS: 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 **SEVERITY: 1 2 3** **DISTRESS: 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 **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

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

Yes **No** **SEVERITY: 1 2 3** **DISTRESS: 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** **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**