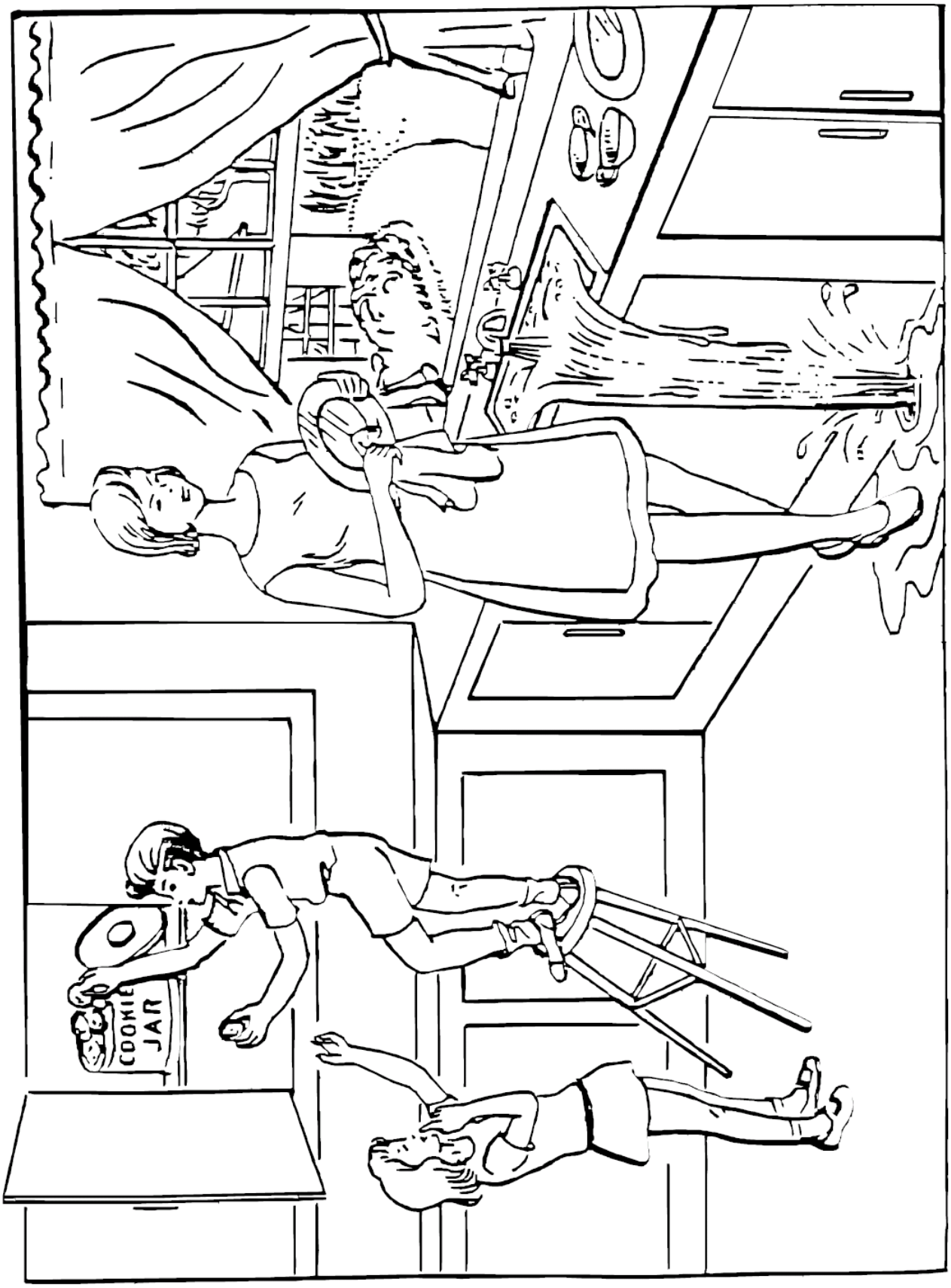
COOKIE
JAR

Down to earth.

I got home from work.

Near the table in the dining room.

They heard him speak on the radio last night.

MAMA

TIP – TOP

FIFTY – FIFTY

THANKS

HUCKLEBERRY

BASEBALL PLAYER

MODIFIED RANKIN SCALE (MRS)

0	No symptoms at all
1	No significant disability despite symptoms; able to carry out all usual duties and Activities
2	Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance
3	Moderate disability; requiring some help, but able to walk without assistance
4	Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance
5	Severe disability; bedridden, incontinent and requiring constant nursing care and Attention
6	Dead

TOTAL (0–6): _____

THE BARTHEL INDEX

Patient Name: _____
Rater Name: _____
Date: _____

Activity	Score
FEEDING 0 = unable 5 = needs help cutting, spreading butter, etc., or requires modified diet 10 = independent	_____
BATHING 0 = dependent 5 = independent (or in shower)	_____
GROOMING 0 = needs to help with personal care 5 = independent face/hair/teeth/shaving (implements provided)	_____
DRESSING 0 = dependent 5 = needs help but can do about half unaided 10 = independent (including buttons, zips, laces, etc.)	_____
BOWELS 0 = incontinent (or needs to be given enemas) 5 = occasional accident 10 = continent	_____
BLADDER 0 = incontinent, or catheterized and unable to manage alone 5 = occasional accident 10 = continent	_____
TOILET USE 0 = dependent 5 = needs some help, but can do something alone 10 = independent (on and off, dressing, wiping)	_____
TRANSFERS (BED TO CHAIR AND BACK) 0 = unable, no sitting balance 5 = major help (one or two people, physical), can sit 10 = minor help (verbal or physical) 15 = independent	_____
MOBILITY (ON LEVEL SURFACES) 0 = immobile or < 50 yards 5 = wheelchair independent, including corners, > 50 yards 10 = walks with help of one person (verbal or physical) > 50 yards 15 = independent (but may use any aid; for example, stick) > 50 yards	_____
STAIRS 0 = unable 5 = needs help (verbal, physical, carrying aid) 10 = independent	_____
TOTAL (0–100):	_____

The Barthel ADL Index: Guidelines

1. The index should be used as a record of what a patient does, not as a record of what a patient could do.
2. The main aim is to establish degree of independence from any help, physical or verbal, however minor and for whatever reason.
3. The need for supervision renders the patient not independent.
4. A patient's performance should be established using the best available evidence. Asking the patient, friends/relatives and nurses are the usual sources, but direct observation and common sense are also important. However direct testing is not needed.
5. Usually the patient's performance over the preceding 24-48 hours is important, but occasionally longer periods will be relevant.
6. Middle categories imply that the patient supplies over 50 per cent of the effort.
7. Use of aids to be independent is allowed.

References

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Gresham GE, Phillips TF, Labi ML. "ADL status in stroke: relative merits of three standard indexes."
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***Int Disability Study.*1988;10:61-63.**

Copyright Information

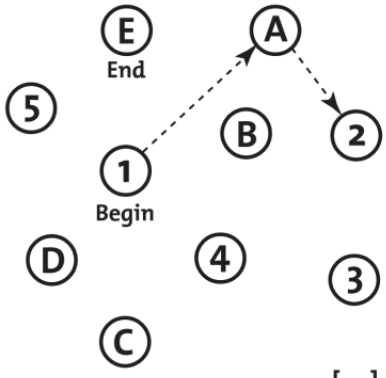
Mini-Mental State Examination (MMSE)

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day? Month?"
5		"Where are we now? State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then the instructor asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible.
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, …) Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.)
30		TOTAL

MONTREAL COGNITIVE ASSESSMENT (MOCA)

Education :
Sex :
Date of birth :
DATE :

VISUOSPATIAL / EXECUTIVE



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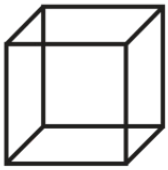


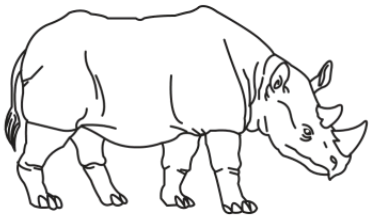
[ ] [ ]

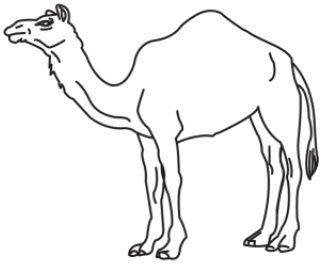
Draw CLOCK (Ten past eleven)
(3 points)

[ ] Contour [ ] Numbers [ ] Hands

POINTS __/5

NAMING





[ ] [ ] [ ] __/3

MEMORY

Read list of words, subject must repeat them. Do 2 trials. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION

Read list of digits (1 digit/ sec.). Subject has to repeat them in the forward order [ ] 2 1 8 5 4
Subject has to repeat them in the backward order [ ] 7 4 2 __/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B __/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt** __/3

LANGUAGE

Repeat : I only know that John is the one to help today. [ ]
The cat always hid under the couch when dogs were in the room. [ ] __/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words) __/1

ABSTRACTION

Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler __/2

DELAYED RECALL

	Has to recall words WITH NO CUE	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

__/5

ORIENTATION

[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City __/6

 Version November 7, 2004
www.mocatest.org

Normal ≥ 26 / 30

TOTAL __/30
Add 1 point if ≤ 12 yr edu

CDR

Instructions: *This form is to be completed by the clinician or other trained health professional based on informant report and neurological exam of the subject. In the extremely rare instances when no informant is available the clinician or other trained health professional must complete this form utilizing all other available information and his/her best clinical judgment. Score only as decline from previous level due to cognitive loss not impairment due to other factors.*

The CDR is a five-point scale in which CDR-0 connotes no cognitive impairment, and then the remaining four points are for various stages of dementia:

0.5 = questionable, or very mild dementia

1 = mild

2 = moderate

3 = severe

The CDR score is derived from information collected from the informant interview as well as the subject interview. The six domains used to construct the overall CDR score are: Memory, Orientation, Judgment and Problem-Solving, Community Affairs, Home and Hobbies, and Personal Care. Each of the domains is rated separately based on the participant's cognitive ability to function in these areas.

CDR

			Impairment		
	None 0	**Questionable 0,5**	**Mild 1**	**Moderate 2**	**Severe 3**
Memory (M)	No memory loss or slightly inconsistent forgetfulness	Consistent slight forgetfulness, partial recollection of events; benign forgetfulness	Moderate memory loss; more marked for recent events; defect interferes with everyday activities	Severe memory loss; only highly learned material retained; new material rapidly lost	Severe memory loss; only fragments remain
Orientation (O)	Fully oriented	Fully oriented except for slight difficulty with time relationships	Moderate difficulty with time relationships; oriented for place at examination; may have geographic disorientation elsewhere	Severe difficulty with time relationships; usually disoriented to time, often to place	Oriented to person only
Judgment & Problem Solving (JPS)	Solves everyday problems & handles business & financial affairs well; judgment good in relation to past performance	Slight impairment in solving problems, similarities and differences	Moderate difficulty in handling problems, similarities and differences; social judgment usually maintained	Severely impaired in handling problems, similarities and differences; social	Unable to make judgments or solve problems
Community Affairs (CA)	Independent function at usual level in job, shopping, volunteer and social groups	Slight impairment in these activities	Unable to function independently at these activities although may still be engaged in some; appears normal to casual inspection	No pretense of independent function outside home. Appears well enough to be taken to functions outside a family home	No pretense of independent function outside home. Appears too ill to be taken to functions outside a family home
Home & Hobbies (HH)	Life at home, hobbies and intellectual interests well maintained	Life at home, hobbies and intellectual interests slightly impaired	Mild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned	Only simple chores preserved; very restricted interests, poorly maintained	No significant function in home
Personal care (PC)	Fully capable of self-care	Fully capable of self-care	Needs prompting	Requires assistance in dressing hygiene, keeping of personal effects	Requires much help with personal care; frequent incontinence

DELAYED RECALL TEST (REY TEST)

Investigator's Instructions

Test versions 1 and 2 may be used alternatively. Mark the test version used for the present evaluation.

Using the correspondant test version table, read the list of words and ask the subject to remember as many of the words as possible. Repeat the procedure five times. Mark the necessary time for each trial.

- On each column (I-V), mark all words that the subject remembers after each reading of the list
- Mark the total number of words under each column
- Mark the time, measured in seconds, for each of the trials, under each column
- The total score for each column is calculated dividing the number of words to the measured time for each trial.

Ask the subject to read the text below the table and underline the previously named words.

- Highlight, on the text, each word marked by the subject.

After 90-120 minutes ask the subject to recall as many of the words as possible, without timing.

- Mark each word the subject remembers in the delayed recall column of the table
- Mark the total number of recalled words at the bottom of the column.

DELAYED RECALL TEST (REY TEST) (2)

Nr. Crt.	Re -evaluation	I	II	III	IV	V	Delayed recall (90-120 min)
1	Pear						
2	Armchair						
3	Carp						
4	Cap						
5	Carriage						
6	Chin						
7	Lake						
8	Soap						
9	Hotel						
10	Horse						
11	Insect						
12	Wardrobe						
13	Pot						
14	Soldier						
15	Frog						
Total number of words							
Time (seconds)							
Total score (number of words/time)							

Recognition: *In the following text* you will find all the words you just read. No matter the form in which they are found in the text, plural form, articulated or not, please underline the words you recognize:

Back from the war (1), the soldier (2) searches for his friends (4) in the bar (5) of a hotel where they usually gathered to clink together pots (7) of wine (8). He took a carriage (9) with a horse (10) but soon discovered that the vehicle (11) was full of insects (12), and so he went on, first, to the lake (13) and washed his whole body with soap (15). Then he shook out his clothes (16) but observed he had to exchange them with the clean ones he had in his wardrobe (17) and then went back home (18). There he put on his new costume (19) and went on cheerfully (20) to the place (21) where he figured he will have a good time. Once he arrived there, he took a seat in an armchair, then ordered a beer (22), a portion of carp (23) and a bread (24). He removed the cap (25) of the bottle (26), drank, ate everything heartily and asked for another pear (27). Suddenly, a frog (28) appeared out of who-knows-where, and began to hop on the floor (29) and our man (30), overly amused, could not help himself a roar (31) of laughter (32).

The Hamilton Depression (HAM-D) Rating Scale provides an indication of depression and, over time, a guide to recovery. It is one of the most widely used and accepted outcome measures for evaluating the severity of depression symptoms. The HAM-D was designed to be administered by a trained professional using a semi-structured interview. Even though Hamilton provided no specific guidelines regarding the administration and scoring of the scale, nor any standardised questions for eliciting information from patients, high inter-rater reliability has been observed.[3] A structured interview guide is available which has been shown to improve reliability further [4]. Several versions of the HAM-D are available, some with additional questions (which are not scored). The HAM-D is also known as the HAM-D_{17}, HRSD and the HDRS. Although this version of the HAM-D lists 21 items, only the first 17 are scored. The remainder provide additional clinical information. It takes about 20 minutes to complete the interview and score the results. Eight items are scored on a 5-point scale, ranging from 0 = not present to 4 = severe. Nine items are scored from 0 - 2. Sum the total of the first seventeen items to arrive at the total score.

Normal	**Mild**	**Moderate**	**Severe**	**Very Severe**
0 - 7	8 - 13	14 - 18	19 - 22	>=23

Privacy - please note - this form does not transmit any information about you or your assessment scores. If you wish to keep your results, either print this document or save this file locally to your computer. If you click 'save' before closing, your results will be saved in this document. These results are intended as a guide to your health and are presented for educational purposes only. They are not intended to be a clinical diagnosis. If you are concerned in any way about your health, please consult with a qualified health professional.

HAMILTON DEPRESSION SCALE

To rate the severity of depression in patients who are already diagnosed as depressed, administer this questionnaire. The higher the score, the more severe the depressed

For each item, write the correct number on the line next to the item. (Only one response per item)

1. **DEPRESSED MOOD** (Sadness, hopeless, helpless, worthless)
   0= Absent

   1= These feeling states indicated only on questioning

   2= These feeling states spontaneously reported verbally

   3= Communicates feeling states non-verbally—i.e., through facial expression, posture, voice, and tendency to weep

   4= Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and non-verbal communication

2. **FEELINGS OF GUILT**
   0= Absent

   1= Self reproach, feels he has let people down

   2= Ideas of guilt or rumination over past errors or sinful deeds **3=** Present illness is a punishment. Delusions of guilt

   4= Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

3. **SUICIDE**
   0= Absent

   1= Feels life is not worth living

   2= Wishes he were dead or any thoughts of possible death to self

   3= Suicidal ideas or gesture

4. **INSOMNIA EARLY**
   0= No difficulty falling asleep

   1= Complains of occasional difficulty falling asleep—i.e., more than 1/2 hour

   2= Complains of nightly difficulty falling asleep

5. **INSOMNIA MIDDLE**
   0= No difficulty

   1= Patient complains of being restless and disturbed during the night

2= Waking during the night—any getting out of bed rates 2 (except for purposes of voiding)

6. **INSOMNIA LATE**
0= No difficulty

1= Waking in early hours of the morning but goes back to sleep

2= Unable to fall asleep again if he gets out of bed

7. **WORK AND ACTIVITIES**
0= No difficulty

1= Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbies

2= Loss of interest in activity; hobbies or work—either directly reported by patient, or indirect in listlessness, indecision and vacillation (feels he has to push self to work or activities)

3= Decrease in actual time spent in activities or decrease in productivity

4= Stopped working because of present illness

8. **RETARDATION: PSYCHOMOTOR** (Slowness of thought and speech; impaired ability to concentrate; decreased motor activity)
0= Normal speech and thought

1= Slight retardation at interview

2= Obvious retardation at interview

3= Interview difficult

4= Complete stupor

9. **AGITATION**
0= None

1= Fidgetiness

2= Playing with hands, hair, etc.

3= Moving about, can't sit still

4= Hand wringing, nail biting, hair-pulling, biting of lips

10. **ANXIETY (PSYCHOLOGICAL)**
0= No difficulty

1= Subjective tension and irritability

2= Worrying about minor matters

3= Apprehensive attitude apparent in face or speech **4=** Fears expressed without questioning

11. **ANXIETY SOMATIC:** Physiological concomitants of anxiety, (i.e., effects of autonomic overactivity, "butterflies," indigestion, stomach cramps, belching, diarrhea, palpitations, hyperventilation, paresthesia, sweating, flushing, tremor, headache, urinary frequency). Avoid asking about possible medication side effects (i.e., dry mouth, constipation)
0=Absent

1=Mild

2=Moderate

3= Severe

4= Incapacitating

12. **SOMATIC SYMPTOMS (GASTROINTESTINAL)**

0= None

1= Loss of appetite but eating without encouragement from others. Food intake about normal

2= Difficulty eating without urging from others. Marked reduction of appetite and food intak

13. **SOMATIC SYMPTOMS GENERAL**

0= None

1= Heaviness in limbs, back or head. Backaches, headache, muscle aches Loss of energy and fatigability

2= Any clear-cut symptom rates 2

14. **GENITAL SYMPTOMS** (Symptoms such as: loss of libido; impaired sexual performance; menstrual disturbances)
0= Absent

1= Mild

2= Severe

15. **HYPOCHONDRIASIS**
0= Not present

1= Self-absorption (bodily)

2= Preoccupation with health

3= Frequent complaints, requests for help, etc. **4=** Hypochondriacal delusions

16. LOSS OF WEIGHT

0= No weight loss

1= Probably weight loss associated with present illness

2= Definite (according to patient) weight loss

3= Not assessed

17. INSIGHT

0= Acknowledges being depressed and ill

1= Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.

2= Denies being ill at all

18. DIURNAL VARIATION

A. Note whether symptoms are worse in morning or evening. If NO diurnal variation, mark none

0= No variation
1= worse in A.M.
2= Worse in A.M.

B. When present, mark the severity of the variation. Mark "None" if NO variation

0= None

1= Mild

2= Severe

19. DEPERSONALIZATION AND DEREALIZATION (Such as: Feelings of unreality; Nihilistic ideas)

0= absent
1= mild
2=moderate
3=severe
4=incapacitating

20. PARANOID SYMPTOMS
0= None
1= Suspicious
2= Ideas of reference
3= Dellusions of reference and persecution

21. OBSESSIONAL AND COMPULSIVE SYMPTOMS
0 = Absent
1 = Mild

2 = Severe

TOTAL Score:

FAQ – interpretation

Caregiver giving information: ……

Instructions for completion: mark in the column which best describes the patient's capacity to accomplish the tasks/ activities mentioned.

Points	Performance of the patient
3	Completely incapable to accomplish the task
2	Needs help to accomplish the task
1	Has difficulties, but accomplishes the task He/She never did it actually; yet, the caregiver considers that the patient can do it, but with difficulty
0	Normal accomplishment He/ She never did it actually, but the caregiver considers that the patient can do it now

Functional Activities Questionnaire (FAQ)

Administration and scoring: This questionnaire should be completed by a reliable informant (caregiver). Check off the appropriate responses to help the physician get a sense of the person's ability to function.

	Normal (0)	Has Difficulty but Manageable (1)	Requires Assistance (2)	Dependant (3)
1. Writing cheques, paying bills, balancing a cheque book.				
2. Assembling tax records, business affairs or papers.				
3. Shopping alone for clothes, household necessities or groceries.				
4. Playing a game of skill or working on a hobby.				
5. Heating water, making a cup of coffee, turning off the stove.				
6. Preparing a balanced meal.				
7. Keeping track of current events				
8. Paying attention to, understanding, and discussing a tv show, book or a magazine				
9. Remembering appointments, family occasions, holidays, and medications.				
10. Travelling out of the neighbourhood, driving, arranging to take buses.				

Total Score _____

*or could never do the activity but could do it now *or never did the activity and would have difficulty now