Geriatric Memory Loss Specialist Intake

Patient Information

Full Name

Date of Birth

Age

Gender

Phone

Address

Referral Information

Referring Physician

Primary Care Physician

Emergency Contact Name

Emergency Contact Phone

Relationship

Presenting Concerns

Memory Issues Noticed Since

Describe Concerns

Any Sudden Changes?

Other Observed Symptoms

Medical and Social History

Past Medical Conditions

Current Medications

History of Falls

History of Substance Use

Living Situation

Family History of Dementia

Mental Status and Function

Difficulty with Activities of Daily Living

Other Cognitive or Mood Changes

Additional Comments