

CNS Screen (PC) - SELF

Patient's name: _____ Date: _____

Informant's name: _____ Relationship _____

The items below reflect possible changes in you from your normal or usual self (e.g. how you used to be).

Rate how much on the following scale:

- 0** -- **No change** – (not present)
- 1** -- **Mild** – (noticeable, but not significant change)
- 2** -- **Moderate** – (significant, but not severe change)
- 3** -- **Severe** – (severe or marked change)

<i>Cognitive</i>	No change	Mild	Moderate	Severe
Difficulty remembering recent or upcoming events	0	1	2	3
Getting lost or not knowing where they are	0	1	2	3
Difficulty keeping track of time	0	1	2	3
Difficulty finding appropriate words	0	1	2	3
Difficulty making decisions or problem-solving	0	1	2	3
<i>IADLs</i>				
Difficulty writing checks, paying bills, etc.	0	1	2	3
Difficulty driving a car	0	1	2	3
Difficulty shopping alone	0	1	2	3
Difficulty performing household tasks	0	1	2	3
Less interested in hobbies and leisure activities	0	1	2	3
<i>Social</i>				
Difficulty holding a conversation	0	1	2	3
Decreased social activity with family or friends	0	1	2	3
Less cooperative, more difficult to get along with	0	1	2	3
Less aware of how others feel, hurtful	0	1	2	3
Less concerned about dressing or grooming	0	1	2	3
<i>Behavior</i>				
Sad or depressed	0	1	2	3
Anxious or worried	0	1	2	3
Impatient or fidgety	0	1	2	3
Less interested in social or group activities	0	1	2	3
Acts impulsively or disinhibited	0	1	2	3
<i>Vegetative / Sensory / Motor</i>				
Changes in appetite and / or eating behaviors	0	1	2	3
Changes in sleep pattern and / or daytime alertness	0	1	2	3
Changes in hearing and / or vision	0	1	2	3
Changes in gait and / or balance	0	1	2	3