Dear Memory Clinic Participant:

Thank you for scheduling an appointment at the Aging Center’s Memory Clinic for a memory evaluation. The Aging Center is located just North of Austin Bluffs Parkway, across the street from the University Shopping Center. On the back of this letter are the details about the cost of the screening. As we discussed on the telephone, your appointment is:

Date:    Time:

Given our long waitlist for the Memory Clinic, if you need to cancel or reschedule your appointment, please give us at least 2 days’ notice so we may attempt to fill the appointment. If not, your name will be removed or placed at the end of our waitlist for rescheduling. Also, given the short amount of time that we have to complete the Memory Clinic screen and provide you with feedback, if you are late to your appointment you may be asked to reschedule.

We have enclosed a short demographic and health questionnaire for you to fill out and bring with you to your appointment. If you have any trouble filling out these forms, just bring them with you, and we will help you with them. On the day of your appointment, please be sure to bring reading glasses and/or hearing aids if you use them. Please call the above number if you have any problems/questions prior to your appointment. We look forward to working with you.

Sincerely,

Memory Clinic Staff

The Aging Center is located in the Lane Center for Academic Health Sciences on the UCCS campus. Please park in any spot labeled HealthCircle or use the designated Handicap spots, if you have the appropriate tag. If these spots are not available, please see the concierge in the Main Floor Lobby.
**Memory Clinic Fee Schedule**

*Fees include basic screening for memory and cognitive problems, a short, printed report, and 5-10 minute review of results with a staff psychologist.

<table>
<thead>
<tr>
<th>Number in household</th>
<th>Annual household income</th>
<th>Available Assets</th>
<th>FEE</th>
<th>TOTAL HOUSEHOLD INCOME + ASSETS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(e.g., savings, properties, stocks, bonds)</td>
<td>$5</td>
<td>$0 - $13,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$45</td>
<td>$57,501 - $64,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$10</td>
<td>$13,001 - $19,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$50</td>
<td>$64,001 - $70,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$15</td>
<td>$19,501 - $25,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$65</td>
<td>$70,001 - $76,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$20</td>
<td>$25,501 - $31,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$80</td>
<td>$76,001 - $82,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$25</td>
<td>$31,501 - $38,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$95</td>
<td>$82,001 - $88,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$30</td>
<td>$38,001 - $44,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$110</td>
<td>$88,001 - $94,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$35</td>
<td>$44,501 - $51,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$130</td>
<td>$94,001 - $100,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$40</td>
<td>$51,001 - $57,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$150</td>
<td>$100,001 and above</td>
</tr>
</tbody>
</table>

Please bring a check or exact cash, as we are unable to make change or take credit/debit cards.

We are committed to serving older adults regardless of ability to pay. While client fees help defray basic clinic operating costs, we recognize that financial hardships may require a reduction in fees.

☐ Please check the box if a fee reduction is requested.   $________ (reduced fee and staff initials)

Supporting documentation may be required.

Quality and affordable services are available at the UCCS Aging Center with support from local and regional grants, foundations, individual contributions, and UCCS assistance. Costs of similar services, if available in the private community, would typically exceed $225. Tax deductible donations are welcome and may be made to the University of Colorado Foundation/UCCS Aging Center, 4863 N. Nevada Ave, Colorado Springs, CO 80918.

Updated 1/2016
Memory Clinic: Demographic Information

Name: ___________________________  Today’s Date: ________________________

Date of Birth: _________________  Age: __________

Birthplace: City/State: __________________________ or Country: ________________

Sex:  Female  Male  Other: __________  Handedness:  Left  Right  Ambidextrous

Occupation: ___________________________  (if retired, note former occupation)

Current Address: ___________________________

____________________________________  Phone: __________

What concerns (if any) do you have about your memory? __________________________

How did you hear about the memory clinic? __________________________

Current income level ($/year):

$10,000  $10,000 to  $25,000 to  $50,000 to  $100,000 or more
or less  $25,000  $50,000  $100,000

Racial/Ethnic background (please mark all that apply):

1 – American Indian or Alaska Native  6 – White
2 – East Asian  7 – Hispanic or Latino
3 – West Asian  8 – Mixed (describe: ____________________)
4 – Black, not of Hispanic Origin  9 – Other (describe: ____________________)
5 – Native Hawaiian or Other Pacific Islander  10 – I do not wish to answer

Partnership status:

Single  Partnered  Married  Legally Separated  Divorced  Widowed
What is the highest degree or level of education you have completed? (check appropriate box AND circle appropriate descriptor)

- Some grade school (1,2,3,4,5,6)
- Junior high school (7,8)
- Some high school – no diploma, no GED (9,10,11,12)
- GED
- High school graduate
- 2 year college, vocational school, or Associate’s degree (1 yr, 2 yrs, completed)
- Some college (freshman, sophomore, junior, senior)
- Bachelor’s degree (Specify: ____________)
- Some graduate school but no degree (number of years: 1,2,3,4,5,6+)
- Master’s degree (Specify: ____________)
- Doctorate or other professional degree (Specify: ____________)

Circle the number that best describes your present health.

<table>
<thead>
<tr>
<th>Poor</th>
<th>Average</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

Have you ever been evaluated for a memory problem? Yes No
If yes, please list when and where you were evaluated (e.g. Memorial Hospital Neurology Department, 1999):

Is there a family history of Alzheimer’s disease or other kind of dementia? Yes No

Have you ever had a head injury? Yes No
If yes, please describe in terms of the type and when (e.g. stroke, 1988; concussion, 2001):

Do you have any hearing problems? Yes No
If yes, how do these affect you on a daily basis? Not at all/Mildly/Moderately/Severely
If yes, do you wear hearing aids? Yes No

Do you have any vision problems? Yes No
If yes, what type of vision problems do you have?
Near-sighted   Far-sighted   Glaucoma   Macular Degeneration   Other ____________
If yes, how do these affect you on a daily basis? Not at all   Mildly   Moderately   Severely
If yes, do you wear glasses or corrective lenses? Yes No

Note: If you wear hearing aids or glasses, please remember to bring them to your appointment.
In the past 12 months, have you experienced or been treated for any of the following? (Indicate YES or NO for each item.)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health problems (depression, anxiety, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis, rheumatism, or other bone or joint diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure or hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol or drug problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic sleeping problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes or high blood sugar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple sclerosis, epilepsy, or other neurological disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperthyroidism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep disorder (sleep apnea, insomnia, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic pain</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please list all medication you are currently taking on a regular basis: (Include name, dosage, and time (e.g. Lipitor, 5mg, 2x day):)

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
Do you smoke tobacco?  
Yes  No
If yes, how many cigarettes/cigars per day:_____________________

Do you use other tobacco products of any kind?  
Yes  No
If yes, please state type and how much you use:_____________________

Do you drink caffeine?  
Yes  No
If yes, please indicate how many cups per day of each of the following:
- Coffee:_______  Tea:_______  Caffeinated soda:_______  Energy Drinks:________

Do you drink alcohol?  
Yes  No
If yes, please indicate how many glasses of alcohol you drink per day or per week:
Drinks/day:______________  Drinks/week:______________

Do you have any difficulty performing any of the following tasks? 
(Check all that apply)

- □ Preparing meals
- □ Shopping
- □ Managing your money
- □ Housekeeping
- □ Taking Medications
- □ Eating
- □ Bathing
- □ Dressing
- □ Toileting
- □ Getting in or out of bed or a chair
- □ Maintaining continence
This is a set of questions about minor memory mistakes that everyone makes from time to time. Please circle the answer that describes how often you do each of these things.

1. Do you decide to do something in a few minutes’ time and then forget to do it?
   
   Very Often    Quite Often    Sometimes    Rarely    Never

2. Do you fail to recognize a place you have visited before?
   
   Very Often    Quite Often    Sometimes    Rarely    Never

3. Do you fail to do something you were supposed to do a few minutes later even though it’s there in front of you, like take a pill or turn off the kettle?
   
   Very Often    Quite Often    Sometimes    Rarely    Never

4. Do you forget something that you were told a few minutes before?
   
   Very often    Quite Often    Sometimes    Rarely    Never

5. Do you forget appointments if you are not prompted by someone else or by a reminder such as a calendar or diary?
   
   Very Often    Quite Often    Sometimes    Rarely    Never

6. Do you fail to recognize a character in a radio or television show from scene to scene?
   
   Very Often    Quite Often    Sometimes    Rarely    Never

7. Do you forget to buy something you planned to buy at a store, like a birthday card, even when you drive or walk by the store?
   
   Very Often    Quite Often    Sometimes    Rarely    Never

8. Do you fail to recall things that have happened to you in the last few days?
   
   Very Often    Quite Often    Sometimes    Rarely    Never
9. Do you repeat the same story to the same person on different occasions?
   Very Often   Quite Often   Sometimes   Rarely   Never

10. Do you intend to take something with you, before leaving a room or going out, but minutes later leave it behind, even though it’s there in front of you?
    Very Often   Quite Often   Sometimes   Rarely   Never

11. Do you forget where you left something that you have just put down, like a magazine or eyeglasses?
    Very Often   Quite Often   Sometimes   Rarely   Never

12. Do you fail to mention or give something to a visitor that you were asked to pass on?
    Very Often   Quite Often   Sometimes   Rarely   Never

13. Do you look at something without realizing that you have seen it moments before?
    Very Often   Quite Often   Sometimes   Rarely   Never

14. If you tried to contact a friend or relative who was out, would you forget to try again later?
    Very Often   Quite Often   Sometimes   Rarely   Never

15. Do you forget what you watched on television the previous day?
    Very Often   Quite Often   Sometimes   Rarely   Never

16. Do you forget to tell someone something you had meant to mention a few minutes ago?
    Very Often   Quite Often   Sometimes   Rarely   Never