

Dementia Questionnaire

Worksheets

Subject's Initials: _____

Examiner Initials: _____

Instructions to rater: For the questions below, "year" relates to the year of onset

Did (does) the subject have any problems with: (please check box)

I. MEMORY/COGNITION

1.	Memory	<input type="checkbox"/> Yes ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
2.	Remembering people's names	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
3.	Recognizing familiar faces	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
4.	Finding way about indoors	<input type="checkbox"/> Yes ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
5.	Finding way on familiar streets	<input type="checkbox"/> Yes ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
6.	Remembering a short list of items	<input type="checkbox"/> Yes ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
7.	Did the trouble with memory begin suddenly or slowly	<input type="checkbox"/> Suddenly <input type="checkbox"/> Slowly	<input type="checkbox"/> DK/NR <input type="checkbox"/> NA
8.	Has the course of the memory problems been a steady downhill progression, have there been abrupt declines, or has it stayed the same	<input type="checkbox"/> No decline <input type="checkbox"/> Abrupt decline <input type="checkbox"/> Steady downhill progression	<input type="checkbox"/> Got better <input type="checkbox"/> NA <input type="checkbox"/> DK/NR
9.	Is a doctor aware of his/her memory problems	<input type="checkbox"/> Yes ↳ Go to 10	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA ↳ Go to 11 ←
10.	What does the doctor believe is causing the problems	<input type="checkbox"/> AD <input type="checkbox"/> Dementia <input type="checkbox"/> Other: _____	<input type="checkbox"/> Confusion <input type="checkbox"/> Nothing wrong <input type="checkbox"/> DK/NR <input type="checkbox"/> Depression <input type="checkbox"/> PD <input type="checkbox"/> NA



Participant ID# _____

Version 2.0 10/15/01

Subject's Initials: _____

II. Expression

11.	Ever have trouble finding the right word or expressing self	<input type="checkbox"/> Yes ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
12.	Talking become less over time	<input type="checkbox"/> Yes ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
13.	Tendency to dwell in the past	<input type="checkbox"/> Yes ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA

III. Daily Functioning

14.	Trouble with household tasks	<input type="checkbox"/> Yes ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
15.	Trouble handling money (balancing checkbook, making change, paying bills, writing checks, etc.)	<input type="checkbox"/> Yes ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
16.	Trouble grasping situations or explanations	<input type="checkbox"/> Yes ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
17.	Does/Has he/she (ever) work(ed) outside the home	<input type="checkbox"/> Yes ↳ Go to 17a	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA ↳ Go to 18
	17a. Is he/she retired? Age _____	<input type="checkbox"/> Yes ↳ Year _____	<input type="checkbox"/> No (Go to 17b) <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
	17b. Does he/she have difficulty at work?	<input type="checkbox"/> Yes ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
18.	Trouble dressing or caring for self including choosing clothes and tying shoes	<input type="checkbox"/> Yes, some trouble <input type="checkbox"/> Yes, needs help ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
19.	Trouble feeding self including cutting meat and buttering bread	<input type="checkbox"/> Yes, some trouble <input type="checkbox"/> Yes, needs help ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA



Participant ID# _____

Subject's Initials: _____

III. Daily Functioning (cont'd)

20.	Trouble controlling bladder or bowels	<input type="checkbox"/> Yes, some trouble <input type="checkbox"/> Yes, needs help ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
	20a. Trouble getting out of bed and into a chair	<input type="checkbox"/> Yes, some trouble <input type="checkbox"/> Yes, needs help ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
	20b. Trouble bathing, including getting in and out of a shower or tub and washing independently	<input type="checkbox"/> Yes, some trouble <input type="checkbox"/> Yes, needs help ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
21.	Agitation and nervousness	<input type="checkbox"/> Yes ↳ Year _____	<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA

IV. Recognition of Problem: (Ask questions in this section **ONLY** if subject has/had memory problems. Code everything as NA otherwise)

22.	Who was the first person to notice he/she was having memory problems	<input type="checkbox"/> Self <input type="checkbox"/> Sibling <input type="checkbox"/> Friend <input type="checkbox"/> NA <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> DK/NR <input type="checkbox"/> Other relative: _____ <input type="checkbox"/> Other: _____
23.	What was noticed (Note the codes associated with the first three symptoms noticed)	a. _____ b. _____ c. _____ 1 Forgets dates/to do things 10 Confusion 2 Forgets names/people 11 Gets lost/disoriented 3 Forgets to eat/has eaten 12 No interest in hobbies/usual activities 4 Forgets things told 13 Less active 5 Forgets where things are/were put 14 Seems different/not him(her)self 6 Unspecified/other forgetfulness 15 Can't use familiar equipment/appliances 7 Problems with job 16 Other 8 Problems driving 17 DK/NR 9 Problems with money/banking 18 NA
24.	When was the last time he/she seemed to be really well or his/her old self	Year _____



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V. Other Problems

25.	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NR	<input type="checkbox"/> NA
26.	Stroke	<input type="checkbox"/> Yes (Go to page 7) ↳ Year _____			<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
27.	Is one side of the body weaker than the other side	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NR	<input type="checkbox"/> NA
28.	Parkinson's disease (tremor, shuffling gait, limb rigidity)	<input type="checkbox"/> Yes ↳ Year _____			<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
29.	Injury to head resulting in loss of consciousness for more than a second or two	<input type="checkbox"/> Yes ↳ Year _____			<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
30.	Seizure or fits	<input type="checkbox"/> Yes ↳ Year _____			<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
31.	Syphilis	<input type="checkbox"/> Yes ↳ Year _____			<input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
32.	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NR	<input type="checkbox"/> NA
33.	Drinking problem	<input type="checkbox"/> Yes ↳ Go to 33a			
	33a. Does he/she have memory problems that coincide with drinking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NR	<input type="checkbox"/> NA
34.	Ever depressed or sad for two weeks or more	<input type="checkbox"/> Yes ↳ Go to 34a			
	34a. Ever seek treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NR	<input type="checkbox"/> NA
35.	Ever very high, euphoric, top of the world	<input type="checkbox"/> Yes ↳ Go to 35a			
	35a. Ever seek treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NR	<input type="checkbox"/> NA



Participant ID# _____

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V. Other Problems (cont'd)

36. Ever seek psychiatric help for any reason	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA Go to 36a Go to 37
36a. Ever hospitalized for psychiatric illness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA Year _____ Where _____
37. Has anyone in the family ever had Down's syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA Who _____
38. Other medical problems other than the ones we have talked about	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA What _____ _____

VI. Medical Contacts

39. Name and address of first doctor seen for memory problems:	_____ _____ _____
40. Did he/she ever receive medications for memory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
41. Did he/she ever have a neurological or psychiatric exam	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA
42. Did subject ever have a CAT scan or MRI of the head	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA Date _____ Where _____
43. Ever in an institution (Nursing Home)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA Date _____ Where _____
44. What was diagnosis given for problems:	_____



Participant ID# _____

Subject's Initials: _____

VII. Other Information

45. How much schooling did (does) he/she have	<input type="checkbox"/> Less than HS <input type="checkbox"/> College graduate <input type="checkbox"/> PhD/MD/JD <input type="checkbox"/> HS graduate <input type="checkbox"/> Some graduate school <input type="checkbox"/> DK/NR <input type="checkbox"/> Some college <input type="checkbox"/> Masters/LLB <input type="checkbox"/> missing
46. How often did/do you have contact with him/her	<input type="checkbox"/> Live together <input type="checkbox"/> 3 or more times a week <input type="checkbox"/> DK/NR <input type="checkbox"/> Daily <input type="checkbox"/> Less than 3 times a week <input type="checkbox"/> missing
46a. Most frequent type of contact	<input type="checkbox"/> Mostly in-person <input type="checkbox"/> Both <input type="checkbox"/> DK/NR <input type="checkbox"/> Mostly phone <input type="checkbox"/> Other: _____ <input type="checkbox"/> missing
47. Did he/she ever drive	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA ↳ Go to 47a
47a. Did he/she ever stop driving	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA ↳ Go to 47b <input type="checkbox"/> No ↳ Go to 47c
47b. Why did he/she stop driving *When stopped? _____	<input type="checkbox"/> Gets lost/confused <input type="checkbox"/> Frequent accidents <input type="checkbox"/> Other _____ <input type="checkbox"/> Poor eyesight <input type="checkbox"/> Fear/nervous driving <input type="checkbox"/> DK/NR <input type="checkbox"/> Illness <input type="checkbox"/> Other cognitive problems <input type="checkbox"/> NA <input type="checkbox"/> Bad coordination/ rxn. time/bad reflexes NOC _____
47c. *Is (did) he/she having (have) any problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA ↳ Go to 47d
47d. What type of problems	<input type="checkbox"/> Gets lost/confused <input type="checkbox"/> Frequent accidents <input type="checkbox"/> Other _____ <input type="checkbox"/> Poor eyesight <input type="checkbox"/> Fear/nervous driving <input type="checkbox"/> DK/NR <input type="checkbox"/> Illness <input type="checkbox"/> Other cognitive problems <input type="checkbox"/> NA <input type="checkbox"/> Bad coordination/ rxn. time/bad reflexes NOC _____
48. <u>If Deceased</u> Was an autopsy done	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA ↳ Where _____



Participant ID# _____

Subject's Initials: _____

Stroke Information

<p>59. Did he/she experience any speech problem (slurring, etc.)</p>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA → Go to 60 ← <input type="checkbox"/> Yes → How long did it last _____ </p>
<p>60. Did he/she have any problems with his/her memory BEFORE the stroke</p>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA </p>
<p>61. Did he/she have any problems with his/her memory AFTER the stroke</p>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA </p>
<p>62. Did his/her memory get better or worse after the stroke</p>	<p> <input type="checkbox"/> No change <input type="checkbox"/> Worse <input type="checkbox"/> DK/NR <input type="checkbox"/> NA <input type="checkbox"/> Better </p>
<p>63. Was he/she given any medications</p>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/NR <input type="checkbox"/> NA <input type="checkbox"/> Yes → What _____ _____ _____ </p>

RETURN TO PAGE 4, QUESTION 27



Participant ID# _____

"I would like to ask you a few questions that require concentration and memory. Some are a little bit more difficult than others. Some questions will be asked more than once."

1. "When were you born?" Record responses.

_ _ month	_ _ day	_ _ _ year
(0) (0)	(0) (0)	(0) (0) (0) (0)
(1) (1)	(1) (1)	(1) (1) (1) (1)
(2) (2)	(2) (2)	(2) (2) (2) (2)
(3) (3)	(3) (3)	(3) (3) (3) (3)
(4) (4)	(4) (4)	(4) (4) (4) (4)
(5) (5)	(5) (5)	(5) (5) (5) (5)
(6) (6)	(6) (6)	(6) (6) (6) (6)
(7) (7)	(7) (7)	(7) (7) (7) (7)
(8) (8)	(8) (8)	(8) (8) (8) (8)
(9) (9)	(9) (9)	(9) (9) (9) (9)

"Where were you born?" Record responses.

place of birth:	answer given	can't do/ refused	not att/ disabled
1.1. city/town _____	(1)	(0)	(9)
1.2. state/country _____	(1)	(0)	(9)

↓
You will ask again in Question 18.

2. "I am going to say three words for you to remember. Repeat them after I have said all three words: 'socks,' blue,' 'charity'."

Do not repeat the words for the participant until after the first trial. The participant may give the words in any order. If there are errors on the first trial, repeat the items up to six times until they are learned.

first trial only:	answer given	error/ refused	not att/ disabled
a. socks	(1)	(0)	(9)
b. blue	(1)	(0)	(9)
c. charity	(1)	(0)	(9)
d. number of presentations necessary for the participant to repeat the sequence (1-7):			
_	(1) (2) (3) (4) (5) (6) (7)		

3. "I would like you to count from 1 to 5."

3.1. (1) able to count forward
(0) unable to count forward Say "1-2-3-4-5"

3.2. "Now I would like you to count backwards from 5 to 1."

Record the responses in the order given:

1st No.	(5) (4) (3) (2) (1)
2nd No.	(5) (4) (3) (2) (1)
3rd No.	(5) (4) (3) (2) (1)
4th No.	(5) (4) (3) (2) (1)
5th No.	(5) (4) (3) (2) (1)

|_|_|_|_|

4. "Spell 'world'."

4.1. (1) able to spell
(0) unable to spell "It's spelled W-O-R-L-D."

4.2. "Now spell 'world' backwards."

Record letters in the order given:

1st letter	(D) (L) (R) (O) (W)
2nd letter	(D) (L) (R) (O) (W)
3rd letter	(D) (L) (R) (O) (W)
4th letter	(D) (L) (R) (O) (W)
5th letter	(D) (L) (R) (O) (W)

|_|_|_|_|

5. "What three words did I ask you to remember earlier?"

The words may be repeated in any order. If the participant cannot give the correct answer after a category cue, provide the three choices listed. If the participant still cannot give the correct answer from the three choices, mark 0 and provide the correct answer.

5.1. socks (3) spontaneous recall
(2) correct word/incorrect form
(2) after "Something to wear."
(1) after "Was it shirt, shoes or socks?"
(0) unable to recall/refused
(provide the correct answer)
(9) not attempted/disabled

5.2. blue (3) spontaneous recall
(2) correct word/incorrect form
(2) after "A color."
(1) after "Was it blue, black, brown?"
(0) unable to recall/refused
(provide the correct answer)
(9) not attempted/disabled

5.3. charity (3) spontaneous recall
(2) correct word/incorrect form
(2) after "A good, personal quality."
(1) after "Was it honesty, charity, modesty?"
(0) unable to recall/refused
(provide the correct answer)
(9) not attempted/disabled

9. "What animals have four legs? Tell me as many as you can."

Discontinue after 30 seconds. Count all correct responses. If the participant gives no response in 10 seconds, and there are at least 10 seconds of remaining time, gently remind (once only) "What (other) animals have four legs?" The first time an incorrect answer is provided, say "I want four-legged animals." Do not correct for subsequent errors.

score (total correct responses):

Score grid with numbers 10-90 and a row of circles 0-9 for marking.

Handwriting practice lines for recording answers.

(Write any additional correct answers on a separate sheet of paper.)

10.1. "In what way are an arm and a leg alike?"

If the participant fails to give an answer that is worth 2 points, mark the appropriate score of 1 or 0. If the answer is not worth 2 points, coach the participant by saying "An arm and a leg are both limbs or extremities." Do not coach for questions 10.2 and 10.3.

- 2 limbs, extremities
1 lesser correct answer (e.g., body parts, both bend, have joints)
0 error (e.g., states differences, gives unrelated answer)/refused
9 not attempted/disabled

10.2. "In what way are laughing and crying alike?"

- 2 expressions of feelings, emotions
1 lesser correct answer (e.g., sounds, expressions)
0 error (e.g., states differences, gives unrelated answer)/refused
9 not attempted/disabled

10.3. "In what way are eating and sleeping alike?"

- 2 necessary bodily functions, essential for life
1 lesser correct answer (e.g., bodily functions, relaxing, "good for you")
0 error (e.g., states differences, gives unrelated answer)/refused
9 not attempted/disabled

11. "Repeat what I say: I would like to go out."

Pronounce the individual words clearly, but with normal tempo of a spoken sentence.

- 2 correct
1 1 or 2 words missed
0 3 or more words missed/refused
9 not attempted/disabled

12. "Now repeat: No ifs, ands or buts."

Pronounce the individual words clearly, but with normal tempo of a spoken sentence. Give no credit if the participant misses the "s."

Table with columns: correct, error/refused, not att/disabled. Rows 12.1 no ifs, 12.2 ands, 12.3 or buts.

13. Hold up Card 39-1 and say: "Please do this."

If the participant does not close her eyes within 5 seconds, prompt by pointing to the sentence and saying "Read and do what this says." If the participant has already read the sentence aloud spontaneously, simply say, "Do what this says."

Allow 5 seconds for the response. Mark 1 if the participant reads the sentence aloud, either spontaneously or after your request, but does not close her eyes. As soon as the participant closes her eyes, say "Open."

- 3 closes eyes without prompting
2 closes eyes after prompting
1 reads aloud, but does not close eyes
0 does not read aloud or close eyes/refused
9 not attempted/disabled

**14. "Please write the following sentence:
I would like to go out."**

Hand the participant a piece of blank paper and a #2 pencil with eraser. If necessary, repeat the sentence word by word as the participant writes. Allow a maximum of 1 minute after the first reading of the sentence for the scored response.

Either printing or cursive writing is allowed. Assign 1 point for each correct word, but no credit for "I." For each word, mark 0 if there are spelling errors or incorrect mixed capitalizations (all letters printed in uppercase is permissible). Do not penalize self-corrected errors.

		correct	error/ refused	not att/ disabled
14.1.	would	1	0	9
14.2.	like	1	0	9
14.3.	to	1	0	9
14.4.	go	1	0	9
14.5.	out	1	0	9

14.6. Note which hand the participant uses to write. If this is not done, ask participant if she is right- or left-handed. (For use in Question 16):

- 1 right
- 2 left
- 9 unknown

15. "Here is a drawing. Please copy the drawing onto this piece of paper."

Hand the participant a piece of paper and Card 39-2. For right-handed participants, present the sample on their left side. For left-handed participants, present the sample on their right side. Allow one minute for copying. In scoring, do not penalize for self-corrected errors, tremors, minor gaps, or overshoots.

15.1. pentagon 1

- 4 5 approximately equal sides
- 3 5 sides, but longest:shortest side is >2:1
- 2 nonpentagon enclosed figure
- 1 2 or more lines, not an enclosure
- 0 less than 2 lines/refused
- 9 not attempted/disabled

15.2. pentagon 2

- 4 5 approximately equal sides
- 3 5 sides, but longest:shortest side is >2:1
- 2 nonpentagon enclosed figure
- 1 2 or more lines, not an enclosure
- 0 less than 2 lines/refused
- 9 not attempted/disabled

15.3. intersection

- 2 4-cornered enclosure
- 1 other than 4-cornered enclosure
- 0 no enclosure/refused
- 9 not attempted/disabled

16. Refer back to Question 14.6 to determine the participant's dominant hand. Hold up a piece of white paper in plain view of the participant but out of her reach, and say:

"Take this paper with your left (right for left-handed person) hand, fold it in half, and hand it back to me."

After saying the whole command, hold the paper within reach of the participant. Do not repeat any part of the command. Do not give visual cues for her to take or return the paper. She may hand it back with either hand.

	correct	error/ refused	not att/ disabled
16.1. takes paper in correct hand	1	0	9
16.2. folds paper in half	1	0	9
16.3. hands paper back	1	0	9

17. "What three words did I ask you to remember earlier?"

The words may be repeated in any order. Administer even if the score = 0 on question 5. If the participant cannot give the correct answer after a category cue, provide the three choices listed. If the participant still cannot give the correct answer from the three choices, mark "0" and provide the correct answer.

- 17.1. socks
 - ③ spontaneous recall
 - ② correct word/incorrect form
 - ② after "Something to wear."
 - ① after "Was it shirt, shoes or socks?"
 - ⑩ unable to recall/refused (provide the correct answer)
 - ⑨ not attempted/disabled

- 17.2. blue
 - ③ spontaneous recall
 - ② correct word/incorrect form
 - ② after "A color."
 - ① after "Was it blue, black, brown?"
 - ⑩ unable to recall/refused (provide the correct answer)
 - ⑨ not attempted/disabled

- 17.3. charity
 - ③ spontaneous recall
 - ② correct word/incorrect form
 - ② after "A good, personal quality."
 - ① after "Was it honesty, charity, modesty?"
 - ⑩ unable to recall/refused (provide the correct answer)
 - ⑨ not attempted/disabled

18. "Would you please tell me again where you were born?"

Ask only when a response was given in Question 1.1 and 1.2. Record the response. Score the responses by checking the match with the responses in Question 1.1 and 1.2.

place of birth:		does not match/ refused	not att/ disabled
18.1. city/town	①	⑩	⑨

18.2. state/country	①	⑩	⑨

19. Special problems?

- ① Yes
- ⑩ No

19.1 Primary problem:

- ① Vision
- ② Hearing
- ③ Inability to write due to injury/illness
- ④ Illiteracy/lack of education
- ⑤ Language (difficulty speaking/ understanding English)
- ⑧ Other, specify: _____

Secondary problem (specify): _____

20. "Please tell me which hand you would normally use to throw a ball to hit a target."

- ① always left
- ② usually left
- ③ no preference
- ④ usually right
- ⑤ always right
- ⑨ unknown

21. "Please tell me which hand you would normally use to hold a toothbrush while cleaning teeth."

- ① always left
- ② usually left
- ③ no preference
- ④ usually right
- ⑤ always right
- ⑨ unknown



SERIAL #

PLEASE MAKE NO MARKS IN THIS AREA

**PLEASE
DO NOT
WRITE
ON THIS
PAGE**



Date: / /

Technician ID: M S

Affix Bar Code Label Here

WHIMS STUDY

Form A

Phase 2:

Administration and Scoring Manual

WHIMS ADMINISTRATION AND SCORING MANUAL

General Instructions to Technician

Administer the cognitive tests included in this packet according to instructions provided to insure that the data obtained are reliable and valid. Specific instructions are provided on the page facing each test score sheet. If you have questions you may call the WHIMS Central Coordinating Center at Wake Forest University School of Medicine (WFUSM).

Each WHIMS task should be administered in the order in which it is presented.

Getting ready for the interview:

Affix a participant barcode label to the cover pages of the Administration and Scoring Manual and the Participant Booklet. Record the date and technician ID. Review the administration instructions and check to see that you have all the materials needed for testing:

- Phase 2: Administration and Scoring Manual
- Phase 2: Participant Booklet
- CERAD Boston Naming Test (green flipbook)
- CERAD Word List Memory Task and Delayed Recognition Test (blue flipbook)
- Stopwatch
- Clipboard
- Pencils
- Tape recorder and blank tapes

Think of yourself as part of the instrumentation. Standardize your behavior during testing and across participants.

Spend a few minutes putting the participant at ease by chatting. Some people relax with a few minutes of light general conversation. Avoid discussing problem areas or the tests to follow.

When she is ready, say something like:

“Now we are going to do a few tasks that involve memory, reading words, drawing, and other things. Then I’ll ask you some general questions about how you are doing. It should take us about 1 hour to complete everything. Each task has been designed to challenge you. That is, some tasks will be easy and others will be harder. You should not worry about how well you are doing, just try to give each one your full attention and do the best you can. I will tell you what you need to do before each task. I cannot tell you how you did or offer any help. Any questions?” (Answer questions).

During the interview:

Follow the administration instructions for each task. Verbatim instructions are provided when indicated. Know when you should prompt and when you should not.

Offer generic phrases of encouragement (“That’s fine” or “You’re doing alright.”) during and between tasks but do not offer any information on the correctness of a particular response (including nonverbal communication like nodding or shaking your head). If a participant continues to ask, explain that you cannot give feedback (“Sorry, but I’m not permitted to tell you how you are doing”).

Do not offer any assistance in completing tasks that is not specifically permitted in the instructions.

Do not place score sheets so the Participant can see them. Use a clipboard or other device to shield the results.

Be aware of the placement of the tape recorder. It is important that both the interviewer and the participant's voices can be heard. You may need to ask the participant to speak louder if her voice becomes too soft during the tasks.

Observe the Participant for signs of strain or stress (e.g., becomes nervous, puts less effort into tasks, starts making excuses). If observed, try to relax her by offering generic reassurances and encouragement (e.g., "You're doing fine", "We can take a break in a few minutes if you like"). You may take a break at certain points during the interview and testing sequence. Do not take a break until after the completion of the Trail Making task unless absolutely necessary. If you take a break, offer the Participant a drink of water or trip to the restroom. Remind the Participant that these tasks are designed to be difficult in places.

After the interview:

Do not tell the Participant how she did (other than to say "Fine").

Quickly review all testing materials for completeness.

After the interview, go back over the Administration and Scoring Manual and score all the questions according to the instructions for each task. Then record the scores on the data summary sheets.

Verify that all the test and interview materials are stapled securely together.

WHIMS Participant questions and suggested responses:

Q: "How did I do?"

A: Say something like: "You did fine."... "Nobody gets all of the questions right."... "I have not tallied the results yet."

Q: "Am I demented (sick, crazy, etc.)?"

A: Say something like: "These tasks don't diagnose illness (dementia)."... "You did fine."... "One of our study doctors will talk with you and look at these results. You may ask him/her."

Q: "Will I have to repeat these tests again?"

A: Say something like: "You may not have to repeat these. But if you do, it won't be for another year."

VERBAL FLUENCY: “ANIMAL CATEGORY”

Administration

Say to the participant:

“I am going to give you a category and I want you to name, as fast as you can, all of the things that belong in that category. For example, if I say ‘articles of clothing,’ you could say shirt, tie or hat. Can you think of other articles of clothing?”

Wait for the participant to give two words. If she succeeds, indicate that the responses are correct and proceed to the test itself. If the participant gives an inappropriate word or reply, correct the response and repeat the instructions. If the participant fails to respond, repeat the instructions. If it becomes clear that the participant still does not understand the instruction, terminate this task, and record “DC,” for discontinued, in the Total Word Count boxes at the bottom of page 5.

After you are satisfied that the participant understands the task and has given two words naming articles of clothing, say:

“That is fine. I want you to name all of the things that belong to another category, that is, ‘animals.’ You will have one minute. I want you to tell me all the animals you can think of in one minute. Ready, begin.”

Allow only one minute. Record all animals named in 15 second intervals in the appropriate section. If the participant discontinues before the end of the time period, encourage her to try and find more words. If she is silent for 15 seconds, repeat the basic instruction (“**I want you to tell me all the animals you can think of**”). If she asks “Do you want 4-legged animals?” reply “**Any animal.**” No extension on the time limit is made in the event that the instruction is repeated in the course of administration.

Scoring Instructions

The participant’s score is the sum of acceptable “animals” given in each 15 second interval. Anything not vegetable or mineral is an animal. Any member of the animal kingdom, real or imaginary, is scored correct, except repetitions and proper nouns. Specifically, each of the following gets credit: a species name and accompanying breeds within the species; male, female and infant names of a species. For example:

<u>Responses</u>	<u>Points</u>
dog	1
terrier	1
dachshund	1
mutt	1
brown dog	0 - repetition
puppy	1
bitch	1
Fido	0 - Proper noun
unicorn	1
amoeba	1
baby dog	0 - repetition
grizzly bear	1
brown bear	1

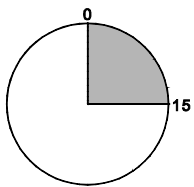
Verbal Fluency Categories

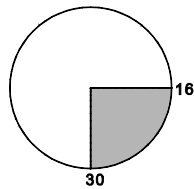
“I am going to give you a category and I want you to name, as fast as you can, all of the things that belong in that category. For example, if I say ‘articles of clothing,’ you could say shirt, tie, or hat. Can you think of other articles of clothing?”

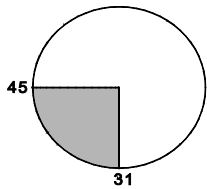
“That is fine. I want you to name all of the things that belong to another category, that is, ‘animals.’ You will have one minute. I want you to tell me all the animals you can think of in one minute. Ready, begin.”

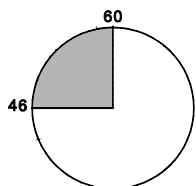
Time Interval

Animals









Word Count: 0-15 sec: 16-30 sec: 31-45 sec: 46-60 sec:

Total Word Count:

BOSTON NAMING TEST

Administration

Say to the participant:

“Now I am going to show you some pictures and I want you to say the name of each picture.”

Present the 15 line drawings in the CERAD Boston Naming Test flip book to the participant. For each picture, ask the following until the participant begins to name the pictures on her own:

“What is the name of this object?” or “Can you name this?”

Record all responses. Correct responses may be recorded using an abbreviation. For example, you may list only the first letter of a correct response instead of the entire word. You may create your own abbreviations but stay consistent. Incorrect responses should be recorded verbatim. If the response is incorrect, reassure the participant (e.g., **“That’s fine.”**) and go to the next item. Allow a maximum of ten seconds for each picture. If the participant can not recall a name, reassure her (e.g., **“That’s OK.”**) and move on to the next item.

Use a prompt for responses that indicate only a part of the picture, e.g., “mattress” for “bed” or “ice” for the “tongs” item (Point to the picture with your pencil or pen and outline the item). Score as incorrect if the designated/required response does not follow.

Semantic or phonetic cues should not be used. A non-specific prompt can be used if the response is too general. For example, if the response to the “canoe” item is “boat”, say **“Is there another name for that?”** You may NOT ask “Isn’t that a special kind of boat?” Likewise, if a response of “harp” is given for the “harmonica” item, prompt for the more specific correct response. If none is given, score as incorrect. Examples of alternative acceptable responses are given below.

Scoring Instructions

If the participant makes an error but corrects it spontaneously, score the response as correct. The participant’s score is the number of correctly named low, medium, and high frequency items.

In general, a more specific correct response is acceptable. For example, a response of “daisy” to the “flower” item is correct.

Regional terms and synonyms, if verified, are counted as correct.

<u>Item</u>	<u>Acceptable Responses</u>
house	schoolhouse hospital home
harmonica	mouth organ French harp blues harp
hammock	swing (colloquial term in the rural South)
tongs	pinchers pincers
mask	doe face false face

Note: “Dice” is not a correct response for “Dominoes” and it does not warrant a prompt. Score “Dice” as incorrect.

Boston Naming Test

(Maximum time: 10 seconds per picture)

“Now I am going to show you some pictures and I want you to say the name of each picture.”

<u>Picture</u>	<u>Response</u>	<u>Incorrect</u>	<u>Correct</u>
[HIGH]			
Tree	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Bed	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Whistle	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Flower (daisy)	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
House	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
[MEDIUM]			
Canoe	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Tooth Brush	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Volcano	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Mask	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Camel	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
[LOW]			
Harmonica	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Tongs	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Hammock	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Funnel	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Dominoes	_____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁

Pictures Correct:

[HIGH]	<input type="checkbox"/>	
[MEDIUM]	<input type="checkbox"/>	
[LOW]	<input type="checkbox"/>	
[TOTAL]	<input type="checkbox"/> <input type="checkbox"/>	(MAX=15)

WORD LIST MEMORY TEST

Administration

To assess participants' ability to remember newly learned information, we administer this free recall task, using 10 common nouns. To insure that participants are familiar with and attend to each word, they are asked to read the words printed on separate cards in the CERAD Word List Memory Test flip books. Present the ten words on the flip cards at a constant rate and then ask her to immediately recall as many as possible. There are three trials, each of which presents the words in a different order.

Say to the participant:

“I am going to show you ten printed words. Read each word out loud as I show it to you. Later I will ask you to recall all ten words.”

Show the words in the first trial at the rate of one word every two seconds. If the participant cannot read the word, say it for her and check the “can't read” column for that word on the Response Sheet. If the participant misreads the word (i.e., “**shone**” for “**shore**”), then ask her to reread the word. If she misreads it again, say the word correctly and ask the participant to repeat it. If the participant later recalls the incorrect word (i.e., “**shone**”), it is scored as an incorrect response.

After the last word in the first trial has been read, say “**Tell me what words you remember.**” Allow a maximum of 90 seconds for the first recall period. Check the box to the right of each word if the participant recalls the word during the 90-second recall period. Write any recalled word not on the list in use in the intrusions lines. Continue with the second and third sets of words in the same way, changing your instructions slightly to encourage the participant. “**Now let's do it again.**” If the participant gives up before 90 seconds, move on to the next trial. If the participant recalls all the words in less than 90 seconds, wait 5-10 seconds to make sure she is not going to enter any intrusions, then ask “**Are you finished?**”

Scoring Instructions

The participant's score for each trial is the number of words correctly recalled and checked in the “Correct Recall” column. Record on each trial the number of words that the participant “recalls” that are not on the list (intrusions). The Total Score is the sum of words correctly recalled for all three trials (i.e., Trial 1 Correct + Trial 2 Correct + Trial 3 Correct = Total Score). Also, sum the number of intrusions for each trial to get the Total Intrusion Score.

CONSTRUCTIONAL PRAXIS

Administration

Hand the participant a pencil with an eraser. Say to the participant:

“Now I’m going to ask you to draw some figures. Some are simple and some are more complicated.”

Point to Item #1 on page 1 of the Participant Booklet and say: **“Now, here is a circle I would like you to draw. Make a copy just below it.”** Wait up to two minutes for completion.

Next, turn the page to Item #2, point to the figure and say: **“Now here’s a drawing of a diamond. Make a copy as best you can, just below it.”** Wait up to two minutes for completion.

Turn the page of the Participant Booklet, point to Item #3 and say: **“That’s fine. Now draw this third figure.”** Wait up to two minutes.

Present item #4 and say: **“This is the hardest figure to draw, but take your time.”** Wait up to two minutes for completion.

Repeat the instructions once if the participant does not understand the first time. If the participant cannot draw the figure in two minutes, reassure her and turn to the next figure. Participants are allowed to erase errors and should use a pencil. Allow multiple self-starts. Do not encourage repeated attempts. Score the last attempt or the one indicated by the participant.

Remove the Participant Booklet from view upon completion of this test.

Scoring Instructions

Only score what is on the page. Do not complete the drawings in your head.

Special Scoring Details

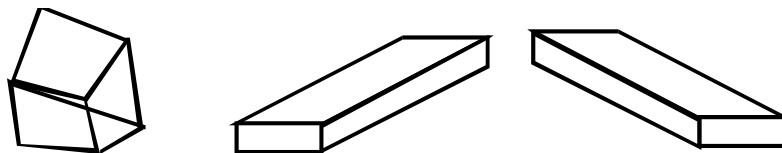
Items 1) and 2): Circle and diamond enclosures allow 1/8 inch gap. Use a ruler if you are unsure of the width of the gap.

Item 2): The longest side may not be more than twice the length of the shortest side.

Item 3):



<u>Scoring</u>	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>
Both rectangles 4-sided	1	1	0	0
Overlap resembles original	1	1	0	1
Total	2	2	0	1



Item 4):

	(A)	(B)	(C)	
<u>Scoring</u>	<u>A</u>	<u>B</u>	<u>C</u>	
Three dimensional	0	1	1	
*Frontal face correctly oriented	1	1	1	
Internal lines correctly drawn	0	0	0	
Opposite sides parallel -	0	1	1	(Use a protractor to determine “within 10°”)
Total	1	3	3	

*Cube face may be oriented left or right, depending on individual perception.

Constructional Praxis
(Maximum time: 2 minutes per figure)

		<u>Incorrect</u>	<u>Correct</u>
Item #1 Circle			
a) closed circle (within 1/8")		<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
b) circular shape		<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Item #2 Diamond			
a) draws 4 sides		<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
b) closes all 4 angles of figure (within 1/8")		<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
c) sides of approximately equal length (The longest side may not be greater than twice the length of the shortest side)		<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Item #3 Rectangles			
a) both figures are 4-sided		<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
b) overlap resembles original		<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Item #4 Cubes			
a) figure is 3-dimensional		<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
b) frontal face correctly oriented (may be right or left oriented)		<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
c) internal lines correctly drawn		<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
d) opposite sides are parallel (within 10°)		<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
TOTAL CORRECT:	Item #1	<input type="checkbox"/>	(MAX = 2)
	Item #2	<input type="checkbox"/>	(MAX = 3)
	Item #3	<input type="checkbox"/>	(MAX = 2)
	Item #4	<input type="checkbox"/>	(MAX = 4)
TOTAL SCORE:		<input type="checkbox"/> <input type="checkbox"/>	(MAX = 11)

WORD LIST RECALL

Administration

This task is to determine how well participants can remember the words presented in the Word List Memory Test.

Say to the participant:

“A few minutes ago I asked you to learn a list of ten words which you read one at a time from cards. Now I want you to try to recall as many of those 10 words as you can. O.K., now tell me as many of those ten words as you can remember.”

Allow the participant a maximum of 90 seconds. Check the box next to each word correctly recalled.

Scoring Instructions

Score the number of words correctly recalled. Also record and score the number of words not on the list (intrusions) that the participant reports. Record under “Intrusions” any word recalled that is not on the list.

Word List Recall

Say to the participant:

“A few minutes ago I asked you to learn a list of ten words which you read one at a time from cards. Now I want you to try to recall as many of those 10 words as you can. Ok, now tell me as many of those 10 words as you can remember.” (Maximum time: 90 seconds)

Check each word
as it is recalled

Arm	<input type="checkbox"/>
Butter	<input type="checkbox"/>
Cabin	<input type="checkbox"/>
Engine	<input type="checkbox"/>
Grass	<input type="checkbox"/>
Letter	<input type="checkbox"/>
Pole	<input type="checkbox"/>
Queen	<input type="checkbox"/>
Shore	<input type="checkbox"/>
Ticket	<input type="checkbox"/>

Intrusions: _____

Totals:
Correct:
Intrusions:

WORD LIST RECOGNITION

Administration

Say to the participant:

“Now I am going to show you a set of words printed on cards. Some of the words are from the list you saw earlier and some of the words I haven’t shown you before. I want you to say YES if the word I show you is one you saw earlier.”

Show the first word and say:

“Is this one of the words you saw earlier?”

Repeat the question or say **“How about this one?”** for each word. Record the participant’s response. Only accept “yes” or “no” responses. If the participant says, “I don’t know,” then say **“Please give your best guess by answering yes or no.”** This section is not timed.

Scoring Instructions

The scores for this test include the number of correctly recognized words previously seen (correct “Yes” responses) and the number of correctly rejected new words (correct “No” responses). Calculate this score by adding the number of shaded boxes checked in the “YES” column and the “NO” column. Record these subtotals in the appropriate boxes (Total YES correct and Total NO correct) and sum them to get the Total Correct Responses.

Word List Recognition

“Now I am going to show you a set of words printed on cards. Some of the words are from the list you saw earlier and some of the words I haven’t shown you before. I want you to say YES if the word I show you is one you saw earlier.” (Only YES or NO responses are acceptable).

	“YES”	“NO”
Church	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1
Coffee	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1
Butter*	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 0
Dollar	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1
Arm*	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 0
<hr/>		
Shore*	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 0
Five	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1
Letter*	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 0
Hotel	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1
Mountain	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1
<hr/>		
Queen*	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 0
Cabin*	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 0
Slipper	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1
Pole*	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 0
Village	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1
<hr/>		
String	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1
Ticket*	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 0
Troops	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1
Grass*	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 0
Engine*	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 0

Total YES Correct: + Total NO Correct: = Total Correct Responses (MAX=20)
 (MAX=10) (MAX=10)

*Original word from Word List Memory Task

CONSTRUCTIONAL PRAXIS - RECALL

Administration

Say to the participant:

“A while ago I showed you some drawings on separate pieces of paper. You looked at each drawing and then drew it on the same sheet of paper. Do you remember them? I would like you to draw them on this sheet, this time from memory.”

Place the Participant Booklet in front of the participant, turn to the blank C-P Recall page, and allow the participant to begin drawing. Allow a maximum of 8 minutes. Otherwise, end the task when the participant indicates she has finished.

Code in the column those drawings that are recalled without prompting. If any of the figures are omitted, give neutral prompt: **“Do you remember any other figures?”** Record in the column “Recall with prompt.”

Scoring Instructions

In the boxes at the bottom of the page, code the total for each item, regardless of whether it was recalled or prompted. Items that are not recalled receive a score of 0. Items recalled but not completely correct get partial credit as indicated.

If the participant draws a figure not previously presented (e.g., intersecting pentagons from Form 39), you may prompt by saying, **“Do you remember any other figures?”**

Constructional Praxis - Recall

“A while ago I showed you some drawings on separate pieces of paper. You looked at each drawing and then drew it on the same sheet of paper. Do you remember them? I would like you to draw them on this sheet, this time from memory.” (Maximum time: 8 minutes)

	Recall		Recall with Prompt	
	<u>No</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>
Item #1 Circle				
a) closed circle (within 1/8”)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
b) circular shape	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Item #2 Diamond				
a) draws 4 sides	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
b) closes all 4 angles of figure (within 1/8”)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
c) sides of approximately equal length (the longest side may not be greater than twice the length of the shortest side)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Item #3 Rectangles				
a) both figures are 4-sided	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
b) overlap resembles original	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
Item #4 Cubes				
a) figure is 3-dimensional	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
b) frontal face correctly oriented (may be right or left oriented)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
c) internal lines correctly drawn	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁
d) opposite sides are parallel (within 10°)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁

If any of the figures are omitted, give neutral prompt: **“Do you remember any other figures?”** Record in the column “Recall with prompt.”

TOTAL CORRECT:

Item 1 (MAX = 2)

Item 2 (MAX = 3)

Item 3 (MAX = 2)

Item 4 (MAX = 4)

TOTAL SCORE: (MAX = 11)

TRAIL MAKING TEST PART A

Sample

Administration

The technician may want to sit to the side of the participant for the Trail Making Test Part A and B in order to quickly identify any errors. If the participant is right-handed sit on her left side and if she is left-handed sit on her right side.

Place the sample item in the Participant Booklet on a table in front of the participant. Give the participant a pencil. Say **“On this page [point] are some numbers. Begin at number 1 [point to 1] and draw a line from 1 to 2 [point to 2], 2 to 3 [point to 3], 3 to 4 [point to 4] and so on, in order, until you reach the end [point to the circle marked “end”]. Draw the lines as fast as you can. Ready? Begin!”**

If the participant makes a mistake point out the error and explain it. If necessary guide the participant’s hand through the trail, eraser end down. Then say **“Now you try it,”** and repeat the original directions starting with **“Begin at number 1…”** Repeat instructions with guidance twice. If the participant still does not understand, terminate TRAILS, Part A **and B** and go on to the next task (Participant Interview).

If the participant completes the sample item correctly and shows that she understands the task say, **“Good!” Let’s try the next one.”** and continue on to the Part A test.

Test

Turn to the Part A and say: **“On this page are numbers from 1 to 25. Do this the same way: Begin at number 1 [point to 1] and draw a line from 1 to 2 [point to 2], 2 to 3 [point to 3], 3 to 4 [point to 4] and so on, in order, until you reach the end [point to 25]. Remember, work as fast as you can. Ready? Begin!”**

Start timing as soon as the instruction is given to begin. Allow a maximum of 300 seconds for the task. **WATCH CLOSELY TO CATCH ERRORS (i.e., CONNECTING DOTS NOT IN SEQUENCE); IDENTIFY AN ERROR IMMEDIATELY AFTER SHE MAKES IT.** Draw a short perpendicular line through the incorrect line. Tell the participant to proceed from the number where the mistake occurred. (That is, from the last number that was correctly connected). **DO NOT STOP TIMING.**

At end say **“That’s fine.”**

Scoring Instructions

Record total time to complete Part A (in seconds). Record the number of circles connected and record the number of errors. If participant makes 5 errors or exceeds 300 seconds, discontinue the test and record “DC” for total time on page 19.

Trail Making Test Part A

Number of Circles Connected (MAX = 25): _____

Total Time (MAX = 300 seconds): _____

Note: Convert all times to SECONDS. For example, 1'45" should be written as "105 seconds," not "145".

Errors: _____

TRAIL MAKING TEST PART B

NOTE: (This test should be administered only if Part A is completed)

Sample

Administration

Say to the participant:

“On this page are some numbers and letters. Begin at number 1 (point to 1) and draw a line from 1 to A (point to A), A to 2 (point to 2), 2 to B (point to B), B to 3 (point to 3), 3 to C (point to C), and so on in order, until you reach the end (point to the circle marked end). Remember, first you have a number (point to 1), then a letter (point to A), then a number (point to 2), then a letter (point to B) and so on. Draw the lines as fast as you can. Ready? Begin.”

If the participant makes a mistake point out the error and explain it. If necessary guide the participant’s hand through the trail, eraser end down. Then say **“Now you try it,”** and repeat the original directions starting with **“Begin at number 1...”** Repeat instructions with guidance twice. If the participant still does not understand, terminate TRAILS, Part B and go on to the next task (Participant Interview).

If the participant completes the sample item correctly and shows that she understands the task say, **“Good! Let’s try the next one.”** and continue on to the Part B test.

Test

Say to the participant:

“On this page are both numbers and letters. Begin at number 1 (point to 1) and draw a line from 1 to A (point to A), A to 2 (point to 2), 2 to B (point to B), B to 3 (point to 3), 3 to C (point to C) and so on, in order, until you reach the end (point to the circle marked end). Remember first you have a number, then a letter, then a number, then a letter, and so on. Do not skip around, but go from one circle to the next in the proper order. Draw the lines as fast as you can. Ready? Begin.”

Start timing as soon as the instruction is given to begin. Allow a maximum of 300 seconds for the task. WATCH CLOSELY IN ORDER TO CATCH ANY ERRORS AS SOON AS THEY ARE MADE. If the participant makes an error, identify it immediately, draw a perpendicular line through the incorrect line, and tell her to proceed from the number or letter where the mistake occurred. (That is, from the last number or letter that was correctly connected). DO NOT STOP TIMING.

Scoring Instructions

Record time in seconds and list the number of errors made. If participant makes 5 errors or goes over 300 seconds, discontinue the test and record “DC” for the total time on page 21.

Trail Making Test Part B

Number of Circles Connected (MAX = 25): _____

Total Time (MAX = 300 seconds): _____

Note: convert all times to SECONDS. For example, 1'45" should be written as "105 seconds," not "145".

Errors: _____

Behavioral and Psychiatric Symptoms

NOTE: This is an appropriate time to allow the participant to take a short break.

Administration

Read the instructions and the questions to the participant. Check either “yes” or “no” in the appropriate box. Record any information relevant to the participant’s response in the “Notes” column. A “yes” is always coded “yes” as long as it occurred during the appropriate time frame. A “maybe” response is also coded as “yes”.

Be aware that the time frame changes for each section of the interview.

Major Depression:

Time frame: Nearly every day for the last two weeks.

1. Sleep difficulty: This question asks about any type of problem with going to sleep, staying asleep once someone has gone to sleep, or oversleeping.
2. Feeling tired: This question includes any aspect of fatigue and lack of energy, no matter how it is phrased by the participant. Accept as “yes” answers like “feeling drained, exhausted, worn out, weary, down and out...”.
3. Poor appetite or overeating: This question asks about a problem with eating, including both eating too much and eating too little. Ask all participants, regardless of their response on Part A, about their weight gain or loss. Ask for their best guess if they do not remember.
4. Little interest or pleasure: This question assesses the amount of interest, enthusiasm, or pleasure the participant has had in everyday activities. “Yes” responses include “everything seems flat or dull; social activities don’t seem to be fun anymore; I haven’t been enjoying things the way I used to...”
5. Feeling down: This question asks about depressed feelings. Accept any word as “yes” that describes negative, sad feelings.
6. Feeling bad about yourself: This question asks about feelings of inadequacy and self-blame. Score as “yes” any response that means the participant blames herself or feels that events are her fault.
7. Trouble concentrating: This question asks for problems associated with thinking or paying attention. Score as “yes” any answer that indicates difficulty with thinking or focusing on a task.
- 8.a. Being fidgety or restless: This question asks about agitation or anxiety. Accept as “yes” responses that indicate nervousness, agitation.... A “yes” response means that you do not have to ask the second half of #8 (moving or speaking slowly).
- 8.b. Moving or speaking slowly: This question assesses a lack of energy associated with mobility and speech. Code as “yes” responses like “haven’t felt like talking; little energy for moving/getting up and down...”
9. Better off dead: This question asks about suicidal thoughts or ideas. A “yes” response means that you should notify the PI.

Behavioral and Psychiatric Symptoms

“Now I am going to ask you about some specific changes in your mood and behavior during the past couple of weeks. I’ll be making some notes as we go along.”

MAJOR DEPRESSION: *“DURING THE LAST TWO WEEKS, have you had any of the following problems NEARLY EVERY DAY?”* (Read each item to the participant and check the box.)

- | | <u>Yes</u> | <u>No</u> | Notes |
|--|--------------------------|--------------------------|-------|
| 1. <i>“Trouble falling or staying asleep, or sleeping too much?”</i> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. <i>“Feeling tired or having little energy?”</i> | <input type="checkbox"/> | <input type="checkbox"/> | |

“For the last two weeks, have you had any of the following problems nearly every day?”

- | | | | |
|---|------------------------------------|--------------------------|--|
| 3. a. <i>“Poor appetite or overeating?”</i> | <input type="checkbox"/> | <input type="checkbox"/> | |
| b. <i>“How much weight have you gained or lost during the past 2 weeks not due to intentional dieting?”</i> | Amount of
Weight change = _____ | | |
| 4. <i>“Little interest or little pleasure in doing things?”</i> | <input type="checkbox"/> | <input type="checkbox"/> | |

“For the last two weeks, have you had any of the following problems nearly every day?”

- | | | | |
|---|--------------------------|--------------------------|--|
| 5. <i>“Feeling down, depressed or hopeless?”</i> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. <i>“Feeling bad about yourself -- or that you are a failure -- or have let yourself and your family down?”</i> | <input type="checkbox"/> | <input type="checkbox"/> | |

“For the last two weeks, have you had any of the following problems nearly every day?”

- | | | | |
|--|--------------------------|--------------------------|--|
| 7. <i>“Trouble concentrating on things, like reading the newspaper or watching television?”</i> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. <i>“Being so fidgety or restless that you were moving around a lot more than usual?”</i> | | | |
| [If ‘No’:] <i>“What about the opposite -- moving or speaking so slowly that other people could have noticed?”</i> | | | |
| [Code ‘Yes’ if ‘Yes’ to either question] | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. <i>“In the last two weeks, have you <u>frequently</u> thought you would be better off dead or of hurting yourself in some way?”</i> | <input type="checkbox"/> | <input type="checkbox"/> | |
| [If ‘Yes’, notify your PI] | | | |

To the interviewer:

10. Total number of “Yes” answers for #1-9:

[Five or more = Probable Major Depressive Disorder]

Panic

Panic Disorders are anxiety disorders that are more commonly seen in women. The illness has a specific set of physical and emotional symptoms. The symptoms include shortness of breath, palpitations, chest pain, choking, GI distress, sense of the unreal, afraid of dying or losing one's mind.

11. Anxiety attack: Anxiety attacks are sudden feelings of panic or fear. Participants will describe these attacks in terms of their symptoms – “I felt this way” or “this happened to me.” Anxiety attacks are different from general anxiety because they start and stop in short periods of time (e.g., minutes or hours). If this question is coded as “yes”, then continue to question #12. If this question is coded as “no”, then skip to question #28.
12. Four attacks in 4 weeks: This question asks for the consistency of these attacks over time. Count any four attacks during any four-week period of time in her life as “yes”. If she answers “no”, then ask if she is afraid of having another attack. A “yes” response to either question means that you should continue to question #13. If both of these questions are answered as “no”, then skip to question #28.
13. Out of the blue: This question asks whether there was an observable or understandable cause of the feeling of fear or panic. Score “yes” when the participant reports that she cannot think of a specific reason or explanation for the panic episode. If this question is coded as “yes”, then ask questions 14 to 26. If this question is coded as “no”, then skip to question #28.
- 14-26. Symptoms of anxiety: Record “yes” if the participant responds to any of the symptoms, using any related words.

Scoring

Add the total number of “yes” responses to questions 14-26 (if given) and record.

PANIC: During the PAST MONTH:

- | | | |
|--|---------------------------------|--------------------------------|
| 11. <i>“Have you had sudden feeling of fear or panic?
We call this an anxiety attack.”</i> | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
| | (Continue) | (If No, go to #28) |
| 12. <i>“Have you ever had four anxiety attacks in a 4-week period?”</i>
[If ‘No’:] <i>“Are you afraid of having another attack?”</i>
[Code ‘Yes’ if ‘Yes’ to either question.] | <input type="checkbox"/> | <input type="checkbox"/> |
| | | (If No, go to #28) |
| 13. <i>“Does this feeling sometimes come <u>suddenly and out of the blue</u>?”</i>
[If unclear:] <i>“In situations where you don’t expect to be nervous or uncomfortable?”</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | (If No, go to #28) |
| <i>“Think about the last really bad time this happened. During that time, did any of these symptoms happen?”</i> | | |
| 14. <i>“Were you short of breath?”</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. <i>“Did your heart race, pound, or skip?”</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. <i>“Did you have chest pain or pressure?”</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. <i>“Did you sweat?”</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. <i>“Did you feel as if you were choking?”</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. <i>“Did you have hot flashes or chills?”</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. <i>“Did you have nausea or an upset stomach or the feeling you were going to have diarrhea?”</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. <i>“Did you feel dizzy, unsteady or faint?”</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. <i>“Did you have tingling or numbness in parts of your body?”</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. <i>“Did you tremble or shake?”</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. <i>“Did things around you seem unreal?”</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. <i>“Were you afraid you were dying?”</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. <i>“Were you afraid you were going crazy or might do something uncontrolled, like shout, urinate, or faint in public?”</i> | <input type="checkbox"/> | <input type="checkbox"/> |

To the Interviewer:
 Add the number of “yes” responses for #14 to #26: Total # of “yes”
 27. [Four or more “YES” responses for items #14-#26=Probable Panic Disorder

Generalized Anxiety

Generalized anxiety refers to general and persistent feelings of nervousness or anxiousness for more than half the days during the last month.

Time frame: MORE THAN HALF THE DAYS IN THE LAST MONTH.

28. Nervous, anxious, or on edge: This question assesses a general feeling of being anxious. Participants may use different words (e.g., apprehensive, tense, sensitive, fidgety, unstrung, panicky, agitated, etc.). If the participant answers “yes”, then continue to ask questions 29 through 34. If she answers “no”, then skip to question #39.
- 29-34. These questions ask about symptoms of anxiety. Record “yes” if the participant expresses any of these symptoms.
35. Total the number of “yes” responses. If the total is two or more, continue to question #36. If the total is 0 or 1, go to question #39.
36. Hard to do work: This question asks whether the general anxiety symptoms have interfered with daily functioning during the last month. Functioning includes anything that a participant might regularly do. If the participant answers “no”, then skip to question #39. If she answers “yes”, proceed to #37.
37. Worry a great deal: This question asks whether the participant has been worried more than usual about several things in her life. A “yes” may be coded only if this has occurred on more than one half the days in the last month. If “yes”, then continue to #38. If “no”, then skip to #39.
- 38.a. Had problems for 6 months: This question asks for a time frame for all the symptoms and problems on this page. If the participant cannot remember when the symptoms started, ask for her best guess.
- 38.b. You are asked to classify the anxiety problem depending on the participant’s pattern of response. If the answers to Items 36, 37 and 38 are ALL “Yes”, the classification is “Generalized Anxiety”. If the answer to Item 38 is “No”, the classification is “Anxiety Not Otherwise Specified”.

GENERALIZED ANXIETY:

	<u>Yes</u>	<u>No</u>	<u>Notes</u>
28. <i><u>“Have you felt nervous, anxious, or on edge <u>ON MORE THAN HALF THE DAYS IN THE LAST MONTH?”</u></u></i>	<input type="checkbox"/>	<input type="checkbox"/>	
	(Continue)	(If No, go to GDS #39)	
<i>“In the last month, have you <u>often</u> (more than half the days) been bothered by any of these problems?”</i>			
29. <i>“Feeling restless so that it is hard to sit still?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
30. <i>“Getting tired very easily”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>“In the last month, have you <u>often</u> been bothered by...”</i>			
31. <i>“Muscle tension, aches, or soreness?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
32. <i>“Trouble falling asleep or staying asleep?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>“In the last month, have you <u>often</u> been bothered by</i>			
33. <i>“Trouble concentrating on things, like reading a book or watching TV?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
34. <i>“Becoming easily annoyed or irritated?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	

To the interviewer: 35a. What is the number of “Yes” responses to #29 through #34? 35. Is the total “yes” number two or more?	Total # “Yes”: <div style="text-align: center; margin-bottom: 10px;"><input style="width: 40px; height: 20px;" type="text"/></div> <input type="checkbox"/> <input type="checkbox"/> (Continue) (If No, go to #39)
---	---

36. <i>“In the last month, have these problems made it hard for you to do your work, take care of things at home, or get along with other people?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	(If No, go to #39)
37. <i>“In the last month, have you been worrying <u>a great deal</u> about <u>different</u> things?”</i> [Code ‘Yes’ only if ‘Yes’ to:] <i>“Has this been on more than one half the days in the last month?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	(If No, go to #39)
38a. <i>“Have you had all of these problems, like feeling nervous, anxious, on edge, and (#29 - #34 that were checked) for as long as six months?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	

To the Interviewer: 38b. Enter total number of “Yes” responses for Items 36 – 38a If number of “Yes” responses = 3 then classify as Probable Generalized Anxiety If number of “Yes” responses <3 then classify as Anxiety, Not Otherwise Specified	Total # of “Yes”: <div style="text-align: center; margin-bottom: 10px;"><input style="width: 40px; height: 20px;" type="text"/></div>
---	--

Alcohol Abuse

Time frame: During past year unless the question asks otherwise.

- 39.a. Drink alcohol: This questions asks about intake of any alcohol at any time during the past year. Check “yes” if the participant has ever taken in any alcohol during this time frame, even if it was one drink. A drink is considered to be 1 beer, 1 glass of wine, or 1 ounce of other alcohol.
- 39.b. Cut down on drinking: This question asks whether the participant has had any awareness of a possible drinking problem. If the participant expresses confusion about the meaning of “cut down”, ask her to use her own definition of “try to cut down” or “cut down on.”
- 40. Complain about drinking: This question asks whether anyone in the participant’s life has ever criticized her for drinking too much. A “yes” response includes “someone has expressed concern.”
- 41. Felt guilty: This question asks about any negative emotions and self-blame the participant has felt about her drinking.
- 42. Five or more drinks: This is a simple frequency question for the consumption of alcohol any single day in the last month.
- 43. Past 6 months: This is a frequency question asking for the consumption of alcohol any single day in the past six months. Note that if the participant answers “yes” to the question, then probe to find out how many times in the past six months she has had 5 or more drinks a day.

Interviewer: If any of the “yes” boxes (shaded) are checked for #39b to #43, continue to ask questions 44 through 48. If none are “yes”, go to the GDS (#50).

- 44. These questions ask whether the participant’s physician (including primary care provider) has advised her to stop drinking, and if so whether she has stopped drinking because of the advice.
- 45-48. These questions ask about the potential of alcohol’s interference with the participant’s daily responsibilities or activities. Check “yes” if she indicates more than one time in the past six months when she has experienced each of the events. Remind the participant of the time frame prior to each question if necessary.

Total the “yes” responses from #44-48 and enter them in the space provided.

ALCOHOL ABUSE: *“Now I will ask you a few questions about your alcohol use. Some of these you may have been asked before.”*

	<u>Yes</u>	<u>No</u>	<u>Notes</u>
39. a. <i>“Did you drink alcohol during the PAST YEAR?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
	(If No, go to GDS, #50)		
b. <i>“Have you thought you should cut down on your drinking?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
40. <i>“Has anyone complained about your drinking?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
41. <i>“Have you felt guilty about your drinking?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
42. <i>“Have you had five or more drinks on a single day in the past month?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
43. <i>“Have you had five or more drinks a day in the past six months?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, how many times? _____ times			

To the Interviewer:
 If one of items 39b-43 are coded ‘Yes’, then ask #44-48. If ‘No’ proceed to GDS (#50).

44. a. <i>“Has a doctor ever suggested that you stop drinking because of a problem with your health?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
	(If No, go to #45)		
b. <i>“If YES, ask “Have you continued to drink during the last six months?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
 <i>“Has any of the following happened to you <u>more than one time</u> in the LAST SIX MONTHS?”</i>			
45. <i>“First, while you were working or taking care of other responsibilities, were you high from alcohol, or hung over?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
46. <i>“What about missing or being late for work or other responsibilities, because you were drinking or hung over?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
47. <i>“What about having a problem getting along with other people while you were drinking?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	
48. <i>“What about driving a car after having several drinks or after drinking too much?”</i>	<input type="checkbox"/>	<input type="checkbox"/>	

To the Interviewer:

49. Enter total number of “Yes” responses for #44 - #48 Total yes:

 One or more of items #44 – 48 is coded “yes” = Probable Alcohol Abuse/Dependence

Geriatric Depression Scale (GDS)

Administration

Each one of these questions asks the participant to indicate her feelings during the past week. Record in the appropriate box. If the participant has difficulty choosing between “yes” and “no” for any question, check “yes”. If a participant has difficulty with or questions the meaning of a phrase, ask her to use her best judgement. Remind the participant of the 1-week time frame throughout the questions if necessary. Read all questions in a neutral and non-leading manner. Do not encourage responses. Responses such as “true” or “that’s right” are acceptable as long as the meaning is clear to the interviewer.

Scoring

Add up the checks in the shaded boxes, and record in the blanks provided. Note: Max = 15.

GDS

Interviewer: Read each statement. Do not elaborate or try to interpret the question. Periodically remind the participant that these questions refer to how they have felt during the past week.

Say: ***“Now I am going to ask you some questions about how you have felt, in general, during the PAST WEEK. Please answer “yes” or “no.” OK? During the past week...”***

- | | Yes | No |
|---|--|--|
| 50. “Have you basically been satisfied with your life?” | <input type="checkbox"/> ₀ | <input checked="" type="checkbox"/> ₁ |
| 51. “Have you dropped many of your activities and interests?” | <input checked="" type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| 52. “Have you felt that your life is empty?” | <input checked="" type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |

During the past week...

- | | | |
|--|--|--|
| 53. “Were you often bored?” | <input checked="" type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| 54. “Were you in good spirits most of the time?” | <input type="checkbox"/> ₀ | <input checked="" type="checkbox"/> ₁ |
| 55. “Were you afraid that something bad was going to happen to you?” | <input checked="" type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| 56. “Were you happy most of the time?” | <input type="checkbox"/> ₀ | <input checked="" type="checkbox"/> ₁ |

During the past week...

- | | | |
|---|--|---------------------------------------|
| 57. “Did you often feel helpless?” | <input checked="" type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| 58. “Did you prefer to stay at home, rather than going out and doing new things?” ... | <input checked="" type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| 59. “Did you feel you had more problems with memory than most?” | <input checked="" type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |

During the past week...

- | | | |
|---|--|--|
| 60. “Did you think it is wonderful to be alive?” | <input type="checkbox"/> ₀ | <input checked="" type="checkbox"/> ₁ |
| 61. “Did you feel pretty worthless the way you are now?” | <input checked="" type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| 62. “Did you feel full of energy?” | <input type="checkbox"/> ₀ | <input checked="" type="checkbox"/> ₁ |
| 63. “Did you feel that your situation is hopeless?” | <input checked="" type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| 64. “Did you think that most people are better off than you are?” | <input checked="" type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |

65. Interviewer: Sum the total shaded boxes.

TOTAL GDS SCORE:

--	--

(MAX=15)

History of Acquired Cognitive and Behavior Changes

Each of these questions asks about different types of cognitive and behavior changes from the participant's normal functional level.

Time frame: OPEN.

Administration

Read the instructions and ask each question. Record the response to each question in the appropriate box.

Try to get the participant to answer "yes" or "no." If the answer is "yes," ask the participant "**About how long ago did you first notice this change?**" and record the response in number of months. If the participant has no idea or doesn't really know an answer to the original question, check "don't know." If the participant indicates a very small change or an inconsistent change, record as "yes." Answers like "once in a while" or "maybe" should be recorded as "yes."

You can make notes to the clinician on the form, if necessary. Try to avoid interpreting the questions or offering additional examples. It is preferable to repeat the question and let the participant answer the best she can.

History of Acquired Cognitive and Behavior Changes

In this section you will ask the participant about changes in her memory, mood and behavior. Record responses in the appropriate box. Try to elicit a “YES” or “NO” response. If the participant answers “Yes” to any of the questions in this section, ask “*About how long ago did you first notice this change?*” and record response in number of months.

“Now I’m going to ask you a few questions about difficulties you might be having in your normal daily routine. O.K.?”

	<u>No</u>	<u>Yes</u>	<u>Don’t Know</u>	<u>How long ago (months)?</u>
66. Memory				
<i>“Have you...”</i>				
a. Had difficulty remembering things that happened recently, in the past few hours or days?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
b. Forgotten conversations that occurred a few hours or days earlier?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
c. Asked the same questions repeatedly?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
d. Forgotten to turn off the stove?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
e. Repeated yourself more?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
67. Language				
<i>“Have you...”</i>				
a. Had trouble finding words in a normal conversation?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
b. Noticed that others have difficulty understanding what you are talking about?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
c. Incorrectly named familiar things?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
68. Personality or Behavior				
<i>“Have you...”</i>				
a. Suddenly become angry or hostile for no apparent reason?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
b. Heard or seen things that are not there?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
c. Been more irritable or angry?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
d. Been overly suspicious of others or have you thought others were trying to get you or hurt you when they weren’t?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
e. Withdrawn from social activity or conversations more than usual?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
69. Orientation for time or place				
<i>“Have you...”</i>				
a. Had trouble remembering the day of the week or month?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
b. Forgotten or gotten confused about important dates, like holidays, doctor’s appointments or days to attend church?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
c. Had trouble finding the bedroom or bathroom at home or in other familiar places (friends’ or relatives’ houses, restaurants)?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
d. Gotten lost in familiar surroundings, such as your neighborhood or in shopping areas?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____

	<u>No</u>	<u>Yes</u>	<u>Don't Know</u>	<u>How long ago (months)?</u>
70. Activities of Daily Living (ADL)				
<i>“Have you...”</i>				
a. Had difficulty (or needed help) handling small sums of money, writing checks, or keeping track of bills?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
b. Had difficulty (or needed help) shopping (e.g., groceries) etc.?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
c. Had difficulty (or needed help) operating simple household appliances (e.g. TV, vacuum cleaner, telephone)?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
d. Had difficulty (or needed help) performing simple household tasks (e.g.making a cup of coffee, setting the table)?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
e. Had difficulty (or needed help) preparing meals?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
f. Had difficulty (or needed help) dressing yourself?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
g. Had difficulty (or needed help) feeding yourself?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
h. Had difficulty (or needed help) grooming yourself?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
i. Had difficulty (or needed help) bathing yourself?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____

71. Social, Community, and Intellectual Activities				
<i>“Have you...”</i>				
a. Participated less in social or community activities (e.g., going to church, visiting friends) than you used to, for reasons other than physical?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
b. Lost special skills, interests, or hobbies (e.g., sewing, gardening, reading, card games) that you used to do?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
c. Said or done things that are potentially embarrassing to yourself or others?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____

72. Judgement and Problem-Solving				
<i>“Have you...”</i>				
a. Had lapses in judgement, such as responding inappropriately to a salesperson or waitress?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
b. Had difficulties understanding TV shows or newspaper articles?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
c. Had more problems than before in organizing a trip or planning a project?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
d. Had difficulty with simple math like adding or subtracting numbers in your head or balancing your checkbook?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
e. Had trouble knowing what to do when ordinary things go wrong like when a light bulb burns out or when a drain gets plugged?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____

73. “Have there been any changes in either your memory or your behavior that I have not asked you about?”

a. no other changes

b. other changes (please describe): _____

Notes:

Summary of Tests

	<u>Test Given</u>		<u>Test Not Given</u>			
	<u>Yes</u>	<u>No</u>	<u>Physical Reason</u>	<u>Not Cooperative</u>	<u>Cognitive Impairment</u>	<u>Other (Specify)</u>
1. Verbal Fluency	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2. Boston Naming	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3. Word List Memory	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4. Constructional Praxis	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5. Word List Recall	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6. Word List Recognition	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7. Constructional Praxis (Recall)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8. Trail Making A	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Trail Making B	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

Data Summary Form: Cognitive Test Battery

<u>Item</u>	<u>Possible Range</u>	<u>Raw Score</u>	<u>Estimated Percentile Scores*</u>		
			<u>50th</u>	<u>10th</u>	<u>5th</u>
Verbal Fluency	n/a	_____	17	12	11
Boston Naming Test	0-15	_____	14	13	12
Word List Memory					
Trial 1	0-10	_____	5	3	2
Trial 2	0-10	_____	7	5	4
Trial 3	0-10	_____	8	6	5
Total Correct Score 1-3	0-30	_____	20	14	11
Total # Intrusions	n/a	_____			
Constructional Praxis	0-11	_____	11	9	8
Word List Recall					
# Correct	0-10	_____	7	5	3
# Intrusions	n/a	_____			
Savings =					
$\left(\frac{\text{WORD LIST RECALL SCORE}}{\text{WORD LIST TRIAL 3 SCORE}} \right) \times 100$		_____	85		48
Word List Recognition					
# correct "Yes"	0-10	_____	10	8	7
# correct "No"	0-10	_____	10	9	8
Constructional Praxis Recall	0-11	_____			
Trail Making Test Part A					
Circles Connected	0-25	_____			
Time	0-300	_____			
# Errors	0-5	_____			
Trail Making Test Part B					
Circles Connected	0-25	_____			
Time	0-300	_____			
# Errors	0-5	_____			

*From: Welsh, et al. Neurology, 44, 1994, 609-614. These norms are approximate and have not been stratified by age or education. They should not be interpreted rigidly.

Data Summary Form: Participant Interview

<u>Item</u>	<u>Possible Range</u>	<u>Raw Score</u>	<u>Interpretation</u>
10	0-9	_____	≥ 5 = Probable Major Depressive Disorder
27	0-13,NA	_____	≥ 4 = Probable Panic Disorder
38b	0-3,NA	_____	3 = Probable Generalized Anxiety Disorder < 3 = Anxiety, Not Otherwise Specified
49	0-6,NA	_____	≥ 1 = Probable Alcohol Abuse/Dependence
65	0-15	_____	≥ 5 = Suggestive of Depression
# Items from 66a through 72e scored "Yes"	0-34	_____	

WHIMS STUDY

Form C

Phase 2:

Friend/Family Member Interview



Instructions to Friend/Family Member

“...Ms. (participant) is participating in a national study of women’s health. She has identified you as someone who knows her well enough to be able to answer a few questions about her memory and her behavior. Your comments will remain confidential and will not be shared with her. This interview will take about 10 minutes. Is this a good time to talk or should I call you back?”

- Now OK (Go to interview)
- Other time
When would it be convenient for me to call you?
Date: _____ Time: _____

1. What is your relationship to Ms. (participant)?
 - Husband
 - Child
 - Sibling
 - Other relative Specify: _____
 - Friend or neighbor
 - Other Specify: _____

2. Does Ms. (participant) live with you?
 - Yes
 - No

3. How often do you see Ms. (participant)?
 - Daily
 - Several times per week
 - Once a week
 - A couple of times a month
 - Less than once a month. How often? _____
 - Doesn’t see participant. Explain: _____

4. How long have you known Ms. (participant)?
 - Less than six months
 - 6 months - 1 year
 - 1 year - 3 years
 - 3 years - 10 years
 - Longer than 10 years How many years? _____

History of Acquired Cognitive and Behavior Changes

In this section you will ask the Family Member/Friend about changes in the participant’s memory, mood and behavior. Record responses in the appropriate box. Try to elicit a “YES” or “NO” response. If the participant answers “Yes” to any of the questions in this section, ask “About how long ago did you notice this change?” and record response in number of months up to one year.

“I’m going to ask you a few questions about difficulties Ms. (Participant’s name) might be having in her normal daily routine. Okay?”

Friend/Family
Member

	<u>No</u>	<u>Yes</u>	<u>Don’t Know</u>	<u>How long ago (months)?</u>
1. Memory				
<i>“Has she...”</i>				
a. Had difficulty remembering things that happened recently, in the past few hours or days?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
b. Forgotten conversations that occurred a few hours or days earlier?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
c. Asked the same questions repeatedly?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
d. Forgotten to turn off the stove?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
e. Repeated herself more?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
2. Language				
<i>“Has she...”</i>				
a. Had trouble finding words in a normal conversation?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
b. Noticed that others have difficulty understanding what she is talking about?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
c. Incorrectly named familiar things?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
3. Personality or Behavior				
<i>“Has she...”</i>				
a. Suddenly become angry or hostile for no apparent reason?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
b. Heard or seen things that are not there?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
c. Been more irritable or angry?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
d. Been overly suspicious of others or has she thought others were trying to get her or hurt her when they weren’t?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
e. Withdrawn from social activity or conversations more than usual?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
4. Orientation for time or place				
<i>“Has she...”</i>				
a. Had trouble remembering the day or month?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
b. Forgotten or gotten confused about important dates, for example, like holidays, doctor’s appointments or days to attend church?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
c. Had trouble finding her way around familiar places like finding the bathroom in her home or at a restaurant she’s gone to before?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
d. Gotten lost in familiar surroundings, such as her neighborhood or in shopping areas?.....	<input type="checkbox"/> ₉	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	_____

Friend/Family
Member

	<u>No</u>	<u>Yes</u>	<u>Don't Know</u>	<u>How long ago (months)?</u>
5. Activities of Daily Living (ADL)				
<i>"Has she..."</i>				
a. Had difficulty (or needed help) handling small sums of money, writing checks, or keeping track of bills?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
b. Had difficulty (or needed help) shopping (e.g., groceries) etc.?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
c. Had difficulty (or needed help) operating simple household appliances (e.g. TV, vacuum cleaner, telephone)?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
d. Had difficulty (or needed help) performing simple household tasks (e.g. making a cup of coffee, setting the table)?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
e. Had difficulty (or needed help) preparing her own meals?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
f. Had difficulty (or needed help) dressing herself?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
g. Had difficulty (or needed help) feeding herself?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
h. Had difficulty (or needed help) grooming herself?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
I. Had difficulty (or needed help) bathing herself?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____

6. Social, Community, and Intellectual Activities				
<i>"Has she..."</i>				
a. Participated in social or community functions (e.g., going to church, visiting friends) less well or less often than she used to, for reasons other than physical?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
b. Lost special skills, interests, or hobbies (e.g., sewing, gardening, reading, card games) that she used to do?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
c. Said or done things that are potentially embarrassing to herself or others?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____

7. Judgement and Problem-Solving				
<i>"Has she..."</i>				
a. Had lapses in judgement, such as responding inappropriately to a salesperson or waitress?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
b. Had difficulties understanding TV shows or newspaper articles?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
c. Had more problems than before in organizing a trip or planning a project?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
d. Had more problems than before with simple math like adding or subtracting numbers in her head or like balancing her checkbook?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____
e. Had trouble knowing what to do when ordinary things go wrong like when a light bulb burns out or when a drain gets plugged?.....	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₉	_____

8. "Have there been any changes in either (participant's) **Notes:** memory or behavior that I have not asked you about?"

- a. no other changes
- b. other changes (please describe): _____

Interviewer: Please answer the following questions based on your observation of the interview with the friend/family member.

9. Do you think the friend/family member has had enough contact with the participant to answer these questions?

Yes

No

Not sure Explain: _____

10. How reliable do you think his/her answers are?

Very reliable, probably accurate

Questionably reliable, possibly inaccurate (Go to 10a)

Unreliable, probably inaccurate (Go to 10a)

10a. What makes this friend/family member less than reliable?

Cognitive impairment

Uncooperative

Unaware of participant's functions and status

Other, Explain: _____

Data Summary Form: Friend/Family Member Interview

<u>Item</u>	<u>Possible Range</u>	<u>Raw Score</u>
# items from 1a through 7e scored "YES"	0-34 _____	

Administration Time

From:
To:

Date: / /

Affix Bar Code Label Here

Clinician's Name

WHIMS STUDY

Form D

Phase 3:

Clinical Evaluation



History of Acquired Cognitive and Behavior Changes

In order to document a history of acquired memory and behavior changes: (1) review the available information (e.g., Form 39, WHI-MS technician's interview of the participant, the technician's interview of the friend/family member, the Cognitive Test Battery, etc.), (2) then interview the participant regarding any changes suggested by the available information until you are ready to make the summary ratings below. You may ask any questions you wish. Make notes in the space provided or on the back of the preceding page.

	Yes	No	Don't Know
1. MEMORY			
Does the participant have an acquired problem with MEMORY as evidenced by such changes as: difficulty remembering things that happened recently, forgetting conversations, repeating questions, forgetting to turn the stove off, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes:

	Yes	No	DK
2. LANGUAGE			
Does the participant have acquired problems with LANGUAGE as evidenced by such changes as: trouble finding words, difficulty communicating, incorrectly naming things, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes:

	Yes	No	DK
3. PERSONALITY OR BEHAVIOR			
Has the participant had unusual changes in her PERSONALITY OR BEHAVIOR such as increased irritability, unexpected episodes of anger or hostility, visual or auditory hallucinations, suspiciousness of others, delusions, social withdrawal, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes:

	Yes	No	DK
4. ORIENTATION FOR TIME OR PLACE			
Does the participant have periods of DISORIENTATION as evidenced by trouble remembering the day of the week or date, forgetting holidays or special dates, being confused about where she is, difficulty finding her way around familiar surroundings, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes:

	Yes	No	DK
5. ACTIVITIES OF DAILY LIVING (ADL)			
Does the participant have difficulty with her ACTIVITIES OF DAILY LIVING such as dressing, feeding, toileting, bathing or grooming, etc. or higher level activities such as handling money, shopping, operating appliances, performing simple household tasks, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes:

2. In the past ten years, has the participant ever been admitted to a hospital for more than two days? Yes No DK
 If YES, specify reason and list hospital admissions with approximate dates:

Cerebrovascular disease

- | | Yes | No | Don't Know | Notes |
|---|--------------------------|--------------------------|--------------------------|------------|
| 3. Has the participant ever had a major or minor stroke? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| If no, skip to #6. If yes, specify: <input type="checkbox"/> major <input type="checkbox"/> minor | | ↓ | | |
| Give dates: Stroke #1 <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<small>m m d d y y y y</small> | | | | (Go to #6) |
| Stroke #2 <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<small>m m d d y y y y</small> | | | | |
| Stroke #3 <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<small>m m d d y y y y</small> | | | | |
| 4. What were the symptoms associated with the stroke? | Yes | No | Don't Know | |
| a. definite loss or alteration of consciousness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| b. minor spells of fainting, blackouts, or dizziness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| c. paralysis of the face | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| d. loss of vision (or field deficit) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| e. language or speech change | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| f. weakness or paralysis of limbs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| g. loss of sensation in limbs or trunk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Was stroke associated with surgical operation(s) or other conditions causing cerebral hypoperfusion? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

Parkinson's disease and other major brain diseases

- | | Yes | No | Don't Know | Notes |
|--|--------------------------|--------------------------|--------------------------|-------|
| 6. Has the participant ever been diagnosed as having Parkinson's disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. If yes, when? <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<small>m m d d y y y y</small> | | | | |
| 8. If yes, has the participant received anti-Parkinson therapy, (e.g. L-dopa)? (Specify: _____) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

Relationship of medical problems to cognitive decline

- | | Yes | No | Don't know |
|---|--------------------------|--------------------------|--------------------------|
| 1. Do you feel that any of the above medical problems are related to the participant's cognitive decline? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain why: _____ | | | |
| _____ | | | |
| _____ | | | |

2. If medical diagnoses associated with cognitive impairment are present, but you feel they are not etiologically related to the participant's condition, explain why not: _____



Clinical Examination

Physical Measurements

1. Height (inches) Inches
2. Weight (pounds) Pounds
3. Blood pressure, standing (mm/Hg) /
4. Blood pressure, sitting (mm/Hg) /

Medical Examination

	Normal	Abnormal	Notes
5. Skin	<input type="checkbox"/>	<input type="checkbox"/>	
6. Head and Neck	<input type="checkbox"/>	<input type="checkbox"/>	
	Absent	Present	
7. Carotid Bruits	<input type="checkbox"/> ↓ (Go to #8)	<input type="checkbox"/>	
IF PRESENT, CHECK SIDE			
7a. Right carotid	<input type="checkbox"/>		
7b. Left carotid	<input type="checkbox"/>		

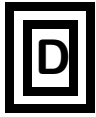
	Normal	Abnormal	Notes
8. Lung	<input type="checkbox"/>	<input type="checkbox"/>	
9. Heart	<input type="checkbox"/>	<input type="checkbox"/>	
10. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
11. Back	<input type="checkbox"/>	<input type="checkbox"/>	
12. Limbs	<input type="checkbox"/>	<input type="checkbox"/>	
13. Joints	<input type="checkbox"/>	<input type="checkbox"/>	
14. Peripheral Vascular	<input type="checkbox"/>	<input type="checkbox"/>	

15. Describe abnormalities: _____

Neurological Examination (cont.)

	Normal	Abnormal	Notes
16. Attention/concentration Describe abnormalities if found: _____	<input type="checkbox"/>	<input type="checkbox"/>	
16a. Digit span (forward) > 4	<input type="checkbox"/>	<input type="checkbox"/>	
16b. Concentration (days of week backward)	<input type="checkbox"/>	<input type="checkbox"/>	
17. Language (Dysarthria, aphasia)	<input type="checkbox"/>	<input type="checkbox"/>	
18. Vision (e.g., cataracts, macular degeneration, glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>	
19. Hearing (e.g., presbycusis)	<input type="checkbox"/>	<input type="checkbox"/>	
20. Cranial nerves 2-12	<input type="checkbox"/>	<input type="checkbox"/>	
21. Describe abnormalities: _____			
<hr/>			
22. Motor examination IF NORMAL, go to #23	Normal <input type="checkbox"/> ↓ (Go to #23)	Abnormal <input type="checkbox"/>	
IF ABNORMAL			
22a. Strength	<input type="checkbox"/>	<input type="checkbox"/>	
22b. Bulk	<input type="checkbox"/>	<input type="checkbox"/>	
22c. Tone (e.g., rigidity, spasticity, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
22d. Movement (e.g., tremor, fasciculation, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
22e. Describe abnormal motor findings: _____			
<hr/>			
22f. Suspect brain origin for problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
<hr/>			
23. Sensation IF NORMAL, go to #24	Normal <input type="checkbox"/> ↓ (Go to #24)	Abnormal <input type="checkbox"/>	
IF ABNORMAL			
23a. Suspect CNS origin (face, arm, leg)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
23b. Suspect PNS origin (Decreased sensation in stocking/glove distribution)	<input type="checkbox"/>	<input type="checkbox"/>	
23c. Suspect cranial nerve origin	<input type="checkbox"/>	<input type="checkbox"/>	

	Normal	Abnormal	Notes
24. Coordination 24a. If abnormal, describe: <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25. Deep tendon reflexes 25a. If abnormal, describe: <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>	<input type="checkbox"/>	<input type="checkbox"/>	
26. Plantar reflexes IF NORMAL, go to #27 IF ABNORMAL 26a. Right foot 26b. Left foot	<input type="checkbox"/> ↓ (Go to #27) <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
27. Pathological reflexes IF PRESENT, CHECK TYPE:	Absent <input type="checkbox"/> (Go to #28)	Present <input type="checkbox"/>	
27a. Grasp <input type="checkbox"/> 27b. Glabellar <input type="checkbox"/> 27c. Suck <input type="checkbox"/> 27d. Snout <input type="checkbox"/> 27e. Palmomentary <input type="checkbox"/> 27f. Other <input type="checkbox"/> 27g. If other, describe: <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>			
28. Gait IF NORMAL, go to Section D IF ABNORMAL, CHECK TYPE:	Normal <input type="checkbox"/> ↓ (Go to Section D)	Abnormal <input type="checkbox"/>	
28a. Parkinsonian <input type="checkbox"/> 28b. Ataxia <input type="checkbox"/> 28c. Apraxic <input type="checkbox"/> 28d. Spastic <input type="checkbox"/> 28e. Other <input type="checkbox"/> 28f. If other, describe: <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/>			



Mini-Mental State Examination (Optional)

*Examiner: This section is **OPTIONAL**. Administer this section only if you believe that you need this information to assess current cognitive status. Remember, the participant has already been administered the (Expanded) Mini-Mental State Exam and the Cognitive Test Battery both of which you should have in your packet. Repeating this test could impose a burden on her. If you decide to skip this section, go to Section E.*

- | | Error | Correct |
|---|--------------------------|--------------------------|
| 1. What is the year? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. What is the season of the year? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. What is the date? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. What is the day of the week? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. What is the month? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Can you tell me where we are? _____
(For instance, what state are we in?) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. What county are we in? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. What city/town are we in? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. What floor of the building are we in? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. What is the name or address of this place? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. I am going to name three objects. After I have said them, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes. Please repeat the names for me: (Score first try. Repeat objects for three trials only). | | |
| a. Hat | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Car | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Tree | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Now I am going to give you a word and ask you to spell it forward and backward. The word is WORLD . First, can you spell it forward? Now spell it backward. (Repeat if necessary, and help participant spell word forward, if necessary) | | |

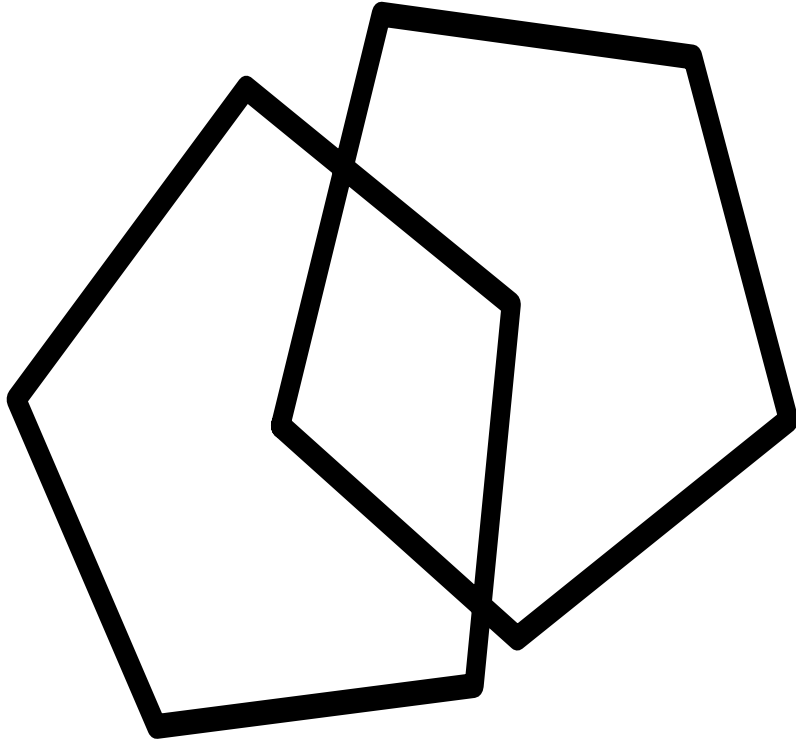
Score number of letters given in correct order: _____
(0 to 5)

- | | Error | Correct |
|---|--------------------------|--------------------------|
| What are the three objects I asked you to remember? | | |
| 13. Hat _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Car _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Tree _____ | <input type="checkbox"/> | <input type="checkbox"/> |

	Error	Correct
16. (Show wrist watch) What is this called? _____	<input type="checkbox"/>	<input type="checkbox"/>
17. (Show pencil) What is this called? _____	<input type="checkbox"/>	<input type="checkbox"/>
18. Please repeat this phrase. "NO IF'S, AND'S OR BUT'S." (Allow only one trial.)	<input type="checkbox"/>	<input type="checkbox"/>
19. Read the words on this page and do what it says. (The paper reads) "CLOSE YOUR EYES" (Score correct if participant closes eyes.)	<input type="checkbox"/>	<input type="checkbox"/>
20. I'm going to give you a piece of paper. When I do, take the paper in your right hand, fold the paper in half with both hands, and put the paper down on your lap. (Read full statement, THEN hand the participant the paper. Do <u>not</u> repeat instructions or coach). Score each of the three stages of commands.		
Right hand	<input type="checkbox"/>	<input type="checkbox"/>
Folds	<input type="checkbox"/>	<input type="checkbox"/>
In lap	<input type="checkbox"/>	<input type="checkbox"/>
21. Write any complete sentence on that piece of paper for me. (Score correct if sentence has a subject and a verb and is sensible.)	<input type="checkbox"/>	<input type="checkbox"/>
22. Here is a drawing. Please copy the drawing on the same paper. (Score correct if the two five-sided figures intersect to form a four-sided figure and if all angles in the five-sided figure are preserved.)	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL SCORE (The sum of the scores for all 22 questions. Each "correct" response receives 1 point)		<input type="checkbox"/> <input type="checkbox"/>

Guide for interpreting scores on the Mini-Mental State Exam: Scores less than or equal to 24 (for individuals with > 8th grade education) or 21 (for individuals with # 8th grade education) are considered to reflect clinically significant cognitive impairment. Scores above 26 are generally considered to reflect normal cognitive functioning. A *diagnosis* of dementia, however, should be made on the basis of all available information (i.e., history, clinical exam, neuropsychological test data and lab work).

**CLOSE
YOUR
EYES**





Psychiatric Symptoms

In order to determine the presence of psychiatric symptoms or a disorder, please:

1. Review the results of the technician's interview of the participant (Behavioral and Psychiatric Symptoms, pgs. 23-29).
2. If there are any positive symptoms or if in your evaluation up to this point you suspect the presence of psychiatric problems, then evaluate the participant further. You may ask whatever questions you wish. Diagnostic criteria are included in the technician interview on pages 23-29.
3. Make your summary rating below for each disorder. Include any comments in the space provided.

- | | | Yes | No |
|----|---|--------------------------|--------------------------|
| 1. | Does the participant have a MAJOR DEPRESSION ?
(CRITERIA FOR DIAGNOSIS: Refer to question # 10 in the Behavioral and Psychiatric Symptoms section of the technician's interview.) | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

- | | | Yes | No |
|----|---|--------------------------|--------------------------|
| 2. | Does the participant have a PANIC DISORDER ?
(CRITERIA FOR DIAGNOSIS: Refer to question # 27 in the Behavioral and Psychiatric Symptoms section of the technician's interview.) | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

- | | | Yes | No |
|----|--|--------------------------|--------------------------|
| 3. | Does the participant have a GENERALIZED ANXIETY DISORDER ?
(CRITERIA FOR DIAGNOSIS: Refer to question # 38b in the Behavioral and Psychiatric Symptoms section of the technician's interview.) | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

4. Does the participant have an **ANXIETY DISORDER, Not Otherwise Specified**? Yes No
(CRITERIA FOR DIAGNOSIS: Refer to question # 38b in the Behavioral and Psychiatric Symptoms section of the technician's interview.)

Comments:

5. Does the participant have an **ALCOHOL ABUSE/DEPENDENCE DISORDER**? Yes No
(CRITERIA FOR DIAGNOSIS: Refer to question # 49 in the Behavioral and Psychiatric Symptoms section of the technician's interview.)

Comments:

6. Does the participant have any **OTHER PSYCHIATRIC DISORDERS** based on your clinical evaluation? Yes No

If YES, describe:



Hachinski Ischemic Scale

Examiner: Rate each of these clinical characteristics based on all the information available to you. Then sum to get a total Hachinski Ischemic score.

<u>Feature</u>	Yes	No	If "YES", score is:
Abrupt onset	<input type="checkbox"/>	<input type="checkbox"/>	2
Stepwise deterioration	<input type="checkbox"/>	<input type="checkbox"/>	1
Fluctuating course	<input type="checkbox"/>	<input type="checkbox"/>	2
Nocturnal confusion	<input type="checkbox"/>	<input type="checkbox"/>	1
Relative preservation of personality	<input type="checkbox"/>	<input type="checkbox"/>	1
Depression	<input type="checkbox"/>	<input type="checkbox"/>	1
Somatic complaints	<input type="checkbox"/>	<input type="checkbox"/>	1
Emotional lability	<input type="checkbox"/>	<input type="checkbox"/>	1
History of hypertension*	<input type="checkbox"/>	<input type="checkbox"/>	1
History of strokes	<input type="checkbox"/>	<input type="checkbox"/>	2
Evidence of associated atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	1
Focal neurological symptoms	<input type="checkbox"/>	<input type="checkbox"/>	2
Focal neurological signs	<input type="checkbox"/>	<input type="checkbox"/>	2

*Defined as either a history of present or previous hypertensive therapy or a current and consistent blood pressure of 160/90 or more.

Sum score for all YES answers



Diagnostic Checklist for Dementia Syndrome

Examiner: After reviewing all the available data sources and completing your evaluation, answer the following questions.

	Yes	No	Don't Know
1. Is there a decline in the participant's memory? (Impaired ability to learn new information or to recall previously learned information)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there a decline in one or more of the following cognitive functions?			
a. Language/speech disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Executive function/problem-solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Visuospatial dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Apraxia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there a decline in functional ability causing significant impairment in social or occupational functioning and representing a significant decline from a previous level of functioning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diagnostic Decision Rules:

- A. *For questions 1 through 3 are there any "YES" responses?*
 If "Yes", please go to Rule B:
 If "No", please classify as having "**No Dementia Syndrome.**"
- B. *Does participant meet all 3 criteria outlined in Questions 1 through 3 (i.e., "yes" responses to questions 1 and 3, plus at least one yes in questions 2a-d)?*
 If "Yes", please classify as having "**Probable Dementia Syndrome.**"
 If "No", please go to Rule C:
- C. *Does the participant have at least 1 "Yes" response to questions 1 and 2?*
 If "Yes", please classify as having "**Minor Cognitive Impairment.**"
 If "No", please go to Rule D:
- D. *Do you think the participant has deficits that exceed "minor cognitive impairment" and are sufficient to classify the participant as having a dementia syndrome, even though some criteria are lacking?*
 If "Yes", please explain reasons for your decision:



Laboratory and Imaging Studies

LABS

If a participant has had identical blood test panel within the last 3 months or less, those records may be submitted in lieu of testing. Otherwise, order and record findings when results are known. (Record most recent results). Attach copy of test results to this form.

	<u>Lab Values</u>	Normal	Abnormal	Not Assessed	Don't Know
1. BUN	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Glucose	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Thyroid (TSH)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. B-12	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Folate	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Test for syphilis	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. CBC with differential (e.g., RBC, Hgb, WBC with diff)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Other (e.g., sed rate _____)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Describe any abnormalities: _____					

Reminder: Please communicate abnormal results to the WHIMS technician so they can be passed on to the participant's primary care physician if consent to do so has been obtained.

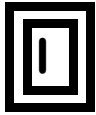
IMAGING STUDIES

	Yes	No	Don't Know
10. Has a head CT or head MRI been done? <input type="checkbox"/> <input type="checkbox"/> /____/____ Facility <small>m m d d y y y y</small> (If YES, obtain a copy. If you are unable to obtain a copy of a previous Head CT or MRI, order a non-contrast head CT scan.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(If NO, or DK, you should order a non-contrast head CT scan and complete this section when results are returned to you. DO NOT ORDER MRI.)

	Yes	No	Don't Know
11. Are CT/MRI results abnormal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. If yes, describe abnormalities _____			

NOTE: Attach a copy of the CT report to this page. Be sure to give the films to the WHIMS technician to be returned to the study Central Coordinating Center.



Classification of Dementia Diagnosis

Examiner: At this point in the diagnostic workup, it is expected that you have reached a conclusion that the participant has a dementia syndrome, and that you are now utilizing the results of the evaluation to refine your diagnostic classification. Using information from the clinical history, clinical examination, laboratory testing, technician interview data and neuropsychological testing, classify the dementia syndrome into specific disease categories.

There will be three broad diagnostic categories: Vascular Dementia, Alzheimer’s Disease, and Other Dementia. The Other Dementia category will include such diagnoses as Mixed Vascular and AD Dementia, Dementia in association with Parkinson’s Disease, Metabolic Dementias, Alcohol-related dementia syndromes, etc. To the best of your ability, please give as specific a diagnosis as possible.

Vascular Dementia Diagnostic Criteria

Criteria for making the diagnosis for Vascular Dementia include **ALL** of the following:

A. The development of multiple cognitive deficits manifested by both:

- | | Yes | No |
|---|--------------------------|--------------------------|
| (1) memory impairment (impaired ability to learn new information or to recall previously learned information) | <input type="checkbox"/> | <input type="checkbox"/> |
| (2) one (or more) of the following cognitive disturbances: | | |
| a. Aphasia (language disturbance) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Apraxia (impaired ability to carry out motor activities despite intact motor function) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Agnosia (failure to recognize or identify objects despite intact sensory function) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting) | <input type="checkbox"/> | <input type="checkbox"/> |

B. The cognitive deficits in Criteria A1 and A2 each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

C. Focal neurological signs and symptoms (e.g., exaggeration of deep tendon reflexes, extensor plantar response, pseudobulbar palsy, gait abnormalities, weakness of an extremity) or laboratory evidence indicative of cerebrovascular disease (e.g., multiple infarctions involving cortex and underlying white matter) that are judged to be etiologically related to the disturbance.

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

D. The deficits do not occur exclusively during the course of a delirium.

	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Does the participant meet ALL of the above criteria, AND is cerebrovascular disease judged to be the only/predominant etiology?

	↓	↓
	STOP	PROCEED

Alzheimer's Disease Diagnostic Criteria

Criteria for making the diagnosis for Alzheimer's Disease include **ALL** of the following:

	Yes	No
A. The development of multiple cognitive deficits manifested by both:		
(1) memory impairment (impaired ability to learn new information or to recall previously learned information)	<input type="checkbox"/>	<input type="checkbox"/>
(2) one (or more) of the following cognitive disturbances:		
(a) Aphasia (language disturbance)	<input type="checkbox"/>	<input type="checkbox"/>
(b) Apraxia (impaired ability to carry out motor activities despite intact motor function)	<input type="checkbox"/>	<input type="checkbox"/>
(c) Agnosia (failure to recognize or identify objects despite intact sensory function)	<input type="checkbox"/>	<input type="checkbox"/>
(d) Disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting)	<input type="checkbox"/>	<input type="checkbox"/>
B. The cognitive deficits in Criteria A1 and A2 each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.	<input type="checkbox"/>	<input type="checkbox"/>
C. The course is characterized by gradual onset and continuing cognitive decline.	<input type="checkbox"/>	<input type="checkbox"/>
D. The cognitive deficits in Criteria A1 and A2 are <u>not</u> due to any of the following:		
(1) Other central nervous system conditions that cause progressive deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's disease, Huntington's disease, subdural hematoma, normal-pressure hydrocephalus, brain tumor)	<input type="checkbox"/>	<input type="checkbox"/>
(2) Systemic conditions that are known to cause dementia (e.g., hypothyroidism, vitamin B ₁₂ or folic acid deficiency, neurosyphilis, HIV infection)	<input type="checkbox"/>	<input type="checkbox"/>
(3) Substance-induced conditions	<input type="checkbox"/>	<input type="checkbox"/>
E. The deficits do not occur exclusively during the course of a delirium.	<input type="checkbox"/>	<input type="checkbox"/>
F. The disturbance is not better accounted for by another disorder (e.g., Major Depressive Disorder, Schizophrenia)	<input type="checkbox"/>	<input type="checkbox"/>
Does the participant meet <u>ALL</u> of the above criteria for Alzheimer's Disease <u>ONLY</u>?	<input type="checkbox"/>	<input type="checkbox"/>
	↓	↓
	STOP	PROCEED

Other Dementia Diagnostic Criteria Categories

In order for the dementia to be classified under one of these specific categories, the participant must have a dementia syndrome, must not meet criteria for Vascular Dementia or Alzheimer’s Disease only, and must meet criteria for the specific diagnosis.

	Yes	No
A. Dementia: Mixed Type (Features of both Alzheimer’s Disease and Vascular Dementia or other etiology).....	<input type="checkbox"/>	<input type="checkbox"/>
B. Normal Pressure Hydrocephalus (Check all that apply)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 1. Abnormal Gait		
<input type="checkbox"/> 2. Incontinence		
<input type="checkbox"/> 3. Hydrocephalus on CT Scan		
C. Parkinson’s Dementia (Check all that apply).....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 1. History of Parkinson’s Disease		
<input type="checkbox"/> 2. Extrapyrmidal Symptoms		
D. Metabolic Dementia: Cause of Dementia Syndrome can be attributed to a metabolic cause (check all that apply).....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 1. B12		
<input type="checkbox"/> 2. Folate		
<input type="checkbox"/> 3. Thyroid Disease		
<input type="checkbox"/> 4. Liver Failure		
<input type="checkbox"/> 5. Kidney Failure		
E. Dementia of Frontal Lobe Type	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 1. Predominance of Frontal-Executive Dysfunction		
<input type="checkbox"/> 2. Language Function Preserved		
<input type="checkbox"/> 3. Diminished Inhibition		
<input type="checkbox"/> 4. Decreased Planning		
F. Alcohol-Related Dementia.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 1. History of severe alcohol abuse		
<input type="checkbox"/> 2. Dementia syndrome persists beyond withdrawal syndrome		
G. Dementia Secondary to Specific Medical Conditions	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 1. Head Trauma		
<input type="checkbox"/> 2. Pick’s Disease		
<input type="checkbox"/> 3. Creutsfeldt-Jakob Disease		
<input type="checkbox"/> 4. Brain Tumor		
<input type="checkbox"/> 5. HIV		
<input type="checkbox"/> 6. Syphilis		
H. Dementia Secondary to Depression	<input type="checkbox"/>	<input type="checkbox"/>
I. Other Dementia Category	<input type="checkbox"/>	<input type="checkbox"/>
Please specify:_____		
J. Dementia, etiology unknown, cannot be determined.....	<input type="checkbox"/>	<input type="checkbox"/>

Please add any comments that you feel would be helpful to explain or document your classification decision making: _____

This is the end of the Clinical Evaluation form. Please arrange to return this booklet along with all lab reports and CT films to the WHI-MS technician working with you.

WHIMS MRI INITIAL CONTACT SCRIPT (10/12/04)**Sample**

(This script can be used via telephone or in person)

“Hi Ms. _____. I am following up with you today to discuss the new WHIMS MRI study. We mailed you an introductory letter and a brochure that explains the study and the process of an MRI scan. Did you have a chance to look at these materials? They explain that an MRI scan is a technique that allows a doctor to see areas of your body without the use of x-rays. Have you had an MRI before? If not, then let me explain a little more about it. The purpose of the MRI is to provide detailed images of internal body structures. For the WHIMS MRI study, we are asking you and other participants to have an MRI scan of the brain. If you have a few minutes, I would like to discuss eligibility for participating in the WHIMS MRI study to see if you are able to participate.”

WHIMS MRI INITIAL CONTACT/SCREENING FORM (10/12/04)

Participant ID: -- Date of Contact: //
M M D D Y Y

Form Completed By: _____

Participant Assent:

1. "May I ask you some questions so I can determine whether or not you are eligible? (Mark participant response)

 Yes (Go to #2) No. "Would you like for us to check back with you again about participating in this study?" Yes "When is a good time for me to call back?" _____ No "Would you please tell me why you don't want to participate in the MRI study? Is it because" (Mark all that apply)

↓

- A. you are too busy to participate?
 B. you are just not interested in participating?
 C. you are fearful of the MRI procedure?
 D. of your or a family member's health?
 E. transportation issues?
 F. of another reason? (Please specify): _____

IF any of A-F are marked STOP HERE. Record data as participant refusal. State to the participant:*"Thank you for your continued contribution to the WHIMS Study. You will continue your WHIMS follow-up as usual."*

2. "Now I am going to ask a few questions to make sure that you do not have any implanted devices that may interfere with an MRI. Do you have . . ." (Mark all that apply)

- A. Pacemaker?
 B. Intracranial aneurysm clip?
 C. Neurostimulator?
 D. Defibrillator?
 E. Intra-ocular ferrous foreign body (metal in the eye?)
 F. Harrington rods?
 G. Non-functioning pacemaker?
 H. Magnetically or electrically activated device
 1. Cochlear implant
 2. TENS unit
 3. Implanted pump (insulin or infusion)
 4. McGee Stapes implant
 I. Other _____
 J. None of the above (Go to question #3.)

IF any of A-I are marked STOP HERE. Record data as participant ineligible due to absolute contraindication. State to the participant:*"Unfortunately we cannot ask you to participate in the WHIMS MRI study as an MRI scan is unsafe for persons who have any of these devices placed in their body. We appreciate your willingness to participate and because of your participation in the WHIMS study, you have already made an important contribution. You will continue your WHIMS follow-up as usual."*

Participant ID: - -

Date of Contact: / /
M M D D Y Y

3. "Do you have any of the following?" (Mark all that apply)

<p>A. <input type="checkbox"/> Metal fragments around critical soft tissue (i.e. shrapnel near spinal cord)?</p> <p>B. <input type="checkbox"/> Prosthetics?</p> <p>C. <input type="checkbox"/> Eyelid spring or wire?</p> <p>D. <input type="checkbox"/> Metallic stent, filter or coil?</p> <p>E. <input type="checkbox"/> Breast tissue expander?</p> <p>F. <input type="checkbox"/> Tattoo or non-removable body piercing?</p> <p>G. <input type="checkbox"/> Difficulty lying flat?</p> <p>H. <input type="checkbox"/> Difficulty breathing?</p> <p>I. <input type="checkbox"/> Claustrophobia? (If checked, administer claustrophobia protocol)</p> <p>J. <input type="checkbox"/> Other _____</p> <p>K. <input type="checkbox"/> No interfering devices or conditions (<i>Go to question #4</i>)</p> <p>If any of A – J are marked: Record on a separate sheet as much information as possible for all items marked and attach comment sheet to this form. <u>Immediately</u> contact the MRI facility to report the device/condition(s) listed above. MRI facility will verify eligibility for MRI compatibility. After verification of eligibility, check one of the following:</p> <p>L. <input type="checkbox"/> MRI facility/PCP cleared – eligible for scanning (<i>Continue to question #4</i>)</p> <p>M. <input type="checkbox"/> Device(s)/condition(s) prevent MRI scanning (STOP: Record data as participant ineligible due to absolute contraindication).</p>
--

4. "Do you want to participate in the WHIMS MRI study?"

<p><input type="checkbox"/> Yes →</p>	<p>"Thank you for agreeing to participate in the new WHIMS MRI study. By joining, you will make an important contribution to our understanding of how the brain changes with age. You will receive a phone call to set up your appointment and to answer any questions you may have about the study."</p>
<p><input type="checkbox"/> No →</p>	<p>"Would you please tell me why you don't want to participate in the WHIMS-MRI study? Is it because: (<i>Mark all that apply</i>)</p> <p>A. <input type="checkbox"/> you are too busy to participate?</p> <p>B. <input type="checkbox"/> you are just not interested in participating?</p> <p>C. <input type="checkbox"/> you are fearful of the MRI procedure?</p> <p>D. <input type="checkbox"/> of your or a family member's health?</p> <p>E. <input type="checkbox"/> transportation issues?</p> <p>F. <input type="checkbox"/> of another reason? (Please specify): _____</p> <p>"We appreciate your willingness to participate and understand that some conditions do prevent people from being able to have an MRI scan. Because of your participation in the WHIMS study, you have already made an important contribution. You will continue with your WHIMS follow-up as usual."</p>

<p>Screening Results: (Data Entry ONLY)</p> <p>5. <input type="checkbox"/> Participant is eligible and willing to participate in the WHIMS-MRI study</p> <p>6. <input type="checkbox"/> Participant is eligible with additional follow-up requested by MRI technician</p> <p>7. <input type="checkbox"/> Participant refusal</p> <p>8. <input type="checkbox"/> Participant is ineligible due to absolute contraindication</p> <p>9. <input type="checkbox"/> Participant is eligible/willing – MRI technologist/PCP cleared device/condition for scanning</p>
--

CLAUSTROPHOBIA PROTOCOL:

Some participants may state that they are claustrophobic. If “severe”, the participant may be ineligible for participation in the WHIMS-MRI study. At the time of screening, if the participant expresses claustrophobia, (and the screening is completed in person), the project manager should show the participant what the MRI scanner looks like. The project manager should provide further description of the procedure:

“During an MRI scan, you lie on a table and the table slowly slides into a cylinder shaped unit. (If form completed in person, show photo). Some people with severe panic disorder or severe claustrophobia cannot go through with an MRI scan. If you think you can go through with the MRI scan, you are eligible to participate. However, you do not have to participate if you feel that your condition will not allow you to be placed inside of the scanner.”

Following claustrophobia protocol, go to question #4.

WHIMS MRI MEDICAL QUESTIONNAIRE

Participant ID: - -

Date Administered: / /
M M D D Y Y

Form Completed By: _____

MEDICAL HISTORY QUESTIONS:

1. "Were you ever hospitalized for a heart attack (coronary, myocardial infarction, or MI)?"

Yes → "What was the date of your last heart attack?" / /
M M D D Y Y Y Y

NOTE: MRI must be scheduled a minimum of 2 months following date of last heart attack. (Year only is acceptable).

- No
- Don't know

2. "Has a doctor ever told you that you have had a stroke?"

- Yes
- No
- Don't know

3. "Has a doctor ever told you that you have had a TIA (a stroke that lasted less than 24 hours)?"

- Yes
- No
- Don't know

4. "Were you ever hospitalized for a carotid endarterectomy or carotid angioplasty (operation for blocked or narrowed arteries in your neck)?"

- Yes
- No
- Don't know

Participant ID: -- Date Administered: //
M M D D Y Y**CURRENT MEDICATION:**

“The following questions are about your current medication use. The timeframe is the past two weeks.”

1. “Over the last two weeks, have you taken any medications, pills or other medicine to thin your blood (anticoagulant)?”

- Yes
 No
 Don't know

2. “Over the last two weeks have you taken any medications for cholesterol or fats in your blood?”

- Yes
 No
 Don't know

3. “Over the last two weeks have you taken any blood pressure pills?”

- Yes
 No
 Don't know

4. “Over the last two weeks have you taken insulin or pills for sugar in your blood?”

- Yes
 No
 Don't know

Participant ID: - -

Date Administered: / /
M M D D Y Y

HORMONE USE QUESTIONS:

“The following questions are about hormone use.”

1. “Are you currently using any female hormones (estrogen or progesterone/progestin) that were prescribed by a doctor?” (These may be in the form of a pill, skin patch, shot, cream, suppository tablet, or vaginal rings). **Mark all that apply.**

	Yes	No	Don't Know
Pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cream, tablet or ring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____			

2. “Which best describes your pattern of hormone use during the past 12 months?”

	All Of the time	Most of the time	Some of the time	Rarely	None	Don't know
Pill used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patches used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal form used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. “Currently, are you using any “natural” hormones that you can get without a doctor’s prescription? These are usually made from plants and often obtained from health food stores or by mail order. They may be in the form of a pill, vaginal cream or suppository, powder, skin cream, or soy-enriched foods.”

Yes →

“What types of “natural” hormones are you using?” (Do not include hormone preparations that need a doctor’s prescription). **Mark all that apply.**

<input type="checkbox"/> Wild yam cream, pills, liquid	<input type="checkbox"/> Red clover, Promensil
<input type="checkbox"/> Progesterone cream, suppositories	<input type="checkbox"/> Soy or phytoestrogen pills, powders, creams, or foods
<input type="checkbox"/> DHEA (dehydroepiandrosterone) pills	<input type="checkbox"/> Other (specify _____)
<input type="checkbox"/> Black cohosh, RemiFemin	<input type="checkbox"/> Don't know
<input type="checkbox"/> Chasteberry, Vitex	

No

Don't know

WHIMS-MRI PROCEDURE FORM (05-16-05)

Participant ID: - -

Date MRI Scheduled: / /
M M D D Y Y

Ppt. Name: _____

Date of Birth: / /
M M D D Y Y Y Y

Time MRI Scheduled: _____

Project Manager: _____

Instructions: This form should be completed on the date of *scheduled* MRI visit.

MRI Technologist: _____

Status of MRI procedure: (check one)

Completed → Date of completion: / /
M M D D Y Y Y Y

<p>*Serious Adverse Event(s): (Mark any event(s) that occurred <u>during</u> scanning)</p> <p><input type="checkbox"/> Claustrophobia</p> <p><input type="checkbox"/> Panic disorder</p> <p><input type="checkbox"/> Other → Specify: _____</p>

Attempted but incomplete →

<p>Reason incomplete (mark all that apply):</p> <p><input type="checkbox"/> Technical problems</p> <p>*Serious Adverse Event(s):</p> <p><input type="checkbox"/> Claustrophobia</p> <p><input type="checkbox"/> Panic disorder</p> <p><input type="checkbox"/> Other → Specify: _____</p> <p>Will this participant be rescheduled for an MRI?</p> <p><input type="checkbox"/> Yes → Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>M M D D Y Y Y Y</small></p> <p><input type="checkbox"/> No</p>
--

Not attempted →

<p>Reason MRI was not attempted (mark all that apply):</p> <p><input type="checkbox"/> Participant did not show up</p> <p><input type="checkbox"/> Participant called to reschedule prior to appointment</p> <p><input type="checkbox"/> Failed eligibility criteria → Specify: _____</p> <p><input type="checkbox"/> Technical problems</p> <p><input type="checkbox"/> Other → Specify: _____</p> <p><input type="checkbox"/> Participant withdrew consent</p> <p>Will this participant be rescheduled for an MRI?</p> <p><input type="checkbox"/> Yes → Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>M M D D Y Y Y Y</small></p> <p><input type="checkbox"/> No</p>

*Checking any item in the Serious Adverse Event box denotes a serious adverse event. A serious adverse event is any event requiring medical intervention. If an event is recorded, please send a detailed description of the event and its resolution to the WHIMS-MRI Coordinating Center within 48 hours.

Email dfelton@wfubmc.edu or landrews@wfubmc.edu or FAX (336) 713-5285.

WHIMS MRI SUB-STUDY

Revised 6/15/04 (Version I)

Quality Confirmation Form

For review and QC of MRI image data received by the MRQC Center

Site number	Subject number	Initials (F/M/L)	Visit number	Date of MRI

Date of received data:	complete			incomplete		
Missing series: (<i>circle missing series</i>)	S1	S2	S3	S4	S5	S6
Missing images (<i>identify missing images in box below series#</i>)						

Image data reviewed and accepted for analysis	yes	no

Additional comments:

MRQC personnel:
Date:

WHIMS-MRI SUMMARY REPORT
WHIMS Clinic Neuroradiologist Form

Participant ID: --

Scan Date: //
M M D D Y Y Y Y

Ppt. Name: _____

Date of Birth: //
M M D D Y Y Y Y

Findings that Require Routine Reporting to WHIMS-MRI PI (check one or more)

_____ **Level 1 – Normal Brain MRI**

_____ **Level 2 – Incidental Age-Related Findings. (Check one or more):**

- _____ non-specific white matter disease
- _____ mild-moderate cerebral atrophy
- _____ other non-urgent findings _____

_____ **Level 3 – Non-urgent disease related findings. (Check one or more):**

- _____ significant remote stroke
- _____ severe white matter disease
- _____ severe cerebral atrophy
- _____ other non-urgent findings _____

Findings that Require Timely (72 hr.) Notification of WHIMS PI (check one or more)

_____ **Level 4 – Urgent findings**

- _____ Acute or subacute infarct
- _____ Acute or chronic subdural hematoma
- _____ Epidural hematoma
- _____ Subarachnoid hemorrhage
- _____ Aneurysm
- _____ Arteriovenous Malformation
- _____ Obstructive Hydrocephalus
- _____ Cerebral Tumor
- _____ Cerebral Abscess
- _____ Other urgent findings _____

Immediately Notify WHIMS PI Name: _____

Telephone: _____ **Fax:** _____

_____, MD, Radiologist WHIMS Clinical Site

Signature

Affix Bar Code Label Here

Test Date:

//

MM / DD / YY

Technician ID: CAS-

WHISCA VISIT #: 1 (Enrollment) 2 3 4 5 6

WHI HRT VISIT: AV2 AV3 AV4 AV5 AV6 AV7 AV8 AV9

TIMING OF WHI HRT VISIT: ANNUAL SEMI-ANNUAL

Women's Health Initiative
Study on Cognitive Aging
(WHISCA)

National Institute on Aging
&
Wake Forest University School of Medicine

Test Administration Instructions

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Booklet Key

S = subject

large numbers indicate the
sequence of events

1 2

Figures like this contain
things YOU DO

Figures like this contain
things YOU SAY

1. Instructions to the technician: Mark all those conditions that have been diagnosed by a physician since the last medical update. If uncertain whether diagnosis was before or after the last medical update, please mark so that conditions are not missed.

Since your last medical update, has a doctor told you that you have any of the following conditions? (Please check all that apply.)

- 1. Mild cognitive impairment
- 2. Alzheimer's disease
- 3. Other form of dementia
- 4. Parkinson's disease
- 5. Epilepsy
- 6. Head injury with loss of consciousness: "blackout" of 10 minutes or more
- 7. Amyotrophic Lateral Sclerosis (Motor neuron disease, or Lou Gherig's disease)
- 8. Depression
- 9. Alcohol addiction
- 10. Drug addiction
- 11. Other neurologic or psychiatric condition

Please specify _____

CHECK THIS BOX IF NONE APPLY

2. Are you still taking the HRT study pills?

Yes _____ No _____

If yes, have you taken it within the past 24 hours?

Yes _____ No _____

3. Are you taking prescription estrogen (pill, patch) not associated with the HRT Study?

Yes _____ No _____

If yes, have you taken/used it within the past 24 hours?

Yes _____ No _____

General Principles

- 1) You may repeat instructions to help clarify the task for participants.
- 2) You may not repeat any to-be-remembered items in any of the memory tasks (CVLT, digit span, or Benton). If the participant asks you to do so, say, "I'm sorry I can't repeat that."
- 3) You may give feedback on sample items on all tests except digits backward.
- 4) You may provide the subject with general feedback such as, "You're doing fine." but not with specific feedback on individual test items.

Introduction Procedure

During this test session, we will do a variety of problem solving and memory tasks. The tasks that you will be performing today are specifically designed so that no one gets the highest score possible on the specific tests. So please just do the best that you can on the tests. As long as you do your best, you are doing what we want you to.

Do you need to use the restroom before we begin because the tests will take about an hour?

Prospective Memory Instructions

1

I will ask you 3 things to remember that will examine everyday memory. First, is remembering a task. At some point during the test session, I will give you this red pencil.

2

Show S the red pencil.

3

When I do, I would like you to circle the title at the top of the page you are working on.

Second, is remembering an appointment. When we are half-way through the test session, I will say: 'We are half way through the test session.' At that point, I want you to ask me when your next WHIMS appointment is. I would like you to say 'Can you tell me when I return for my next WHIMS visit?' or something like that.

Third, is remembering a hidden belonging. What I am going to do now is put something of yours away, and see if you can remember to ask me for it when I say, 'We have finished this test.' I also want you to remember where I put it. Can you give me a personal item such as your name tag (comb, pen, or other inexpensive belonging)? I am hiding it here in _____
(name the location).

4

Take S's belonging and hide it out of sight (e.g. in a drawer or in your pocket). Tell S where object is hidden.

5

When I say, 'We have finished this test' I want you to ask me for your _____ (name the belonging) and tell me where I put it. Any questions?

Vocabulary Test

2

Give the *S* the participant booklet opened to the Vocabulary Test and read the instructions.

Ask *S* to perform practice items.

Answer questions as necessary.

Watch closely to ensure that *S* circles the appropriate responses for each word.

When *S* is ready to begin test, say:

4

Start stop watch when the *S* has turned to the 1st page . Give *S* three minutes to complete the test.

Make sure *S* does not circle more than 1 response for each target word. If she does, ask her to choose which response is closer in meaning to the target word.

Make sure *S* does not skip any pages.

At the end of three minutes, ask *S* to stop.

5

Take *S*'s Participant Booklet after she is finished with the Vocabulary test and turn to the first divider sheet.

If the *S* circles an incorrect word for one of the examples, go over the example with the *S* trying to determine if she misunderstood the instructions or does not understand the meaning of the word. If she misunderstood the instructions, clarify them for her. If the *S* does not know the meaning of an example word, determine whether she knows the meaning of any of the remaining examples. Write 'does not know meaning' next to any example items she does not know. With the second set of examples, be sure that she understands to look for the response on the SAME line as the target word. As long as the *S* understands the instructions (regardless of whether she understands the specific word example) continue with the test.

If the *S* asks if she should guess, say:

If you are not sure,
it is best not to
guess.

1

For this first task I will read the instructions out loud while you read them to yourself.

Instructions

The first word in line 1 is *big*.

One of the other words means the same as *big*. The word *large* has been circled because it means the same as *big*.

big	ill	large	down	sour
-----	-----	-------	------	------

The first word in line 2 is *ancient*. Circle one of the other words that means the same as *ancient*.

ancient	dry	long	happy	old
---------	-----	------	-------	-----

You should have circled *old* because it means the same or nearly the same as *ancient*.

In each of the following lines circle the word that means the same or almost the same as the first word.

quiet	blue	still	tense	watery
safe	secure	loyal	passive	young
brave	hot	cooked	red	courageous

3

You will have 3 minutes to complete this test. Please work as quickly as you can without sacrificing accuracy. Don't turn the page until I tell you to begin. Any questions?

Turn the page and begin.

California Verbal Learning Test – Trials 1, 2, and 3

Read the appropriate list in a loud, clear voice leaving a one second interval after each word.

Be sure to record ALL responses verbatim in the space provided. Write legibly.

You can tell S the number of trials. Do not tell S the number of words in list.

1

Let's suppose you were going shopping on Monday. I'm going to read a list of items for you to buy. Listen carefully, and when I'm through, I want you to say back as many of the items as you can. It doesn't matter what order you say them in – just tell me as many as you can. Are you ready?

2

LIST A Monday

drill
plums
vest
parsley
grapes
paprika
sweater
wrench
chives
tangerines
chisel
jacket
nutmeg
apricots
pliers
slacks

OK, tell me as many items as you can.

4

I'm going to repeat Monday's shopping list. Again, I want you to say back as many items as you can, in any order. Be sure to also include the items on the list that you told me the first time.

6

I'm going to repeat Monday's shopping list. Again, I want you to say back as many items as you can, in any order, including items you may have already told me.

Experimenter may not repeat a word. If S asks for a repeat, say:

Tell me what you think I said.

California Verbal Learning Test - List B, List A Short-Delay Free Recall

8

Now let's suppose that you planned to go shopping again on Tuesday. I'm going to read a new list of items for you to buy. When I'm through, I want you to say back as many as you can, in any order.

9

LIST B
Tuesday

toaster
cherries
halibut
ginger
pineapple
spatula
oregano
flounder
sage
lemons
cod
skillet
peaches
salmon
cinnamon
bowl

OK, tell me as many items as you can

11

Now I'd like you to tell me all of the shopping items you can from the Monday list - the 1st list that I read to you.

California Verbal Learning Test - List A Short-Delay Cued Recall

13

Tell me all of the shopping items from the Monday list that are:
(category)

List A
Short-Delay Cued
Recall Responses

14

Spices and Herbs

16

Fruits

15

Tools

17

Clothing

Time of Short-Delay Cued Recall Completion: _____ . (hh:mm AM/PM)
(Record the time from your watch after completing this part of the test.)

Benton Visual Retention Test

General Guidelines

- a) S may not see a figure again at any time, even after the test is over.
- b) S cannot use a straight edge.
- c) When S verbally states a correction to the drawing, encourage her to self-correct. Write subject comments in booklet only when she refuses to self-correct.

Subject spontaneous self-corrections

- a) S can erase, but don't volunteer this information; say so only if S asks or indicates that she would like to change her drawing.
- b) If S redraws lines, and does not erase the old ones, you can say, "You may erase." Leave it to S to decide whether to erase anything. S is scored on what she draws. You may explain that she is scored on what she draws when you answer questions about erasures.
- c) If S crosses-out a design and redraws it, ask her if she wants the new figure to replace the crossed-out figure. Also, ask S if she wants the redrawn design in the same place as the crossed-out design.
- d) If you use a replacement page, be sure to write the same small number in the upper left corner of the new page to indicate the design number and to indicate which edge is upright. Then staple the replacement page over the gray portion of the original page.

Subject Feedback - General

- a) Discourage S from quitting by encouraging her to continue. For example, "The test is more difficult than it seems. Do the best you can" or "As long as you do your best, you are doing what we want" or "Although you may feel you are doing poorly, your participation is valuable as long as you do the best that you can."

Specific Subject Behaviors Requiring Specific Responses

- a) If S draws before the 10 seconds have elapsed, say "Please don't draw." Give her a new sheet after covering the figure and say "I want you to draw on a clean sheet of paper." Use a spare sheet of paper to replace the figure is covered is most likely to happen on the 1st and 3rd figures after you tell S to draw everything she sees.
- b) If S puts a "?" where a design should be, ask her if it is part of the figure, or if she is just indicating that she did not know what was supposed to be there. Make a note that S didn't know what was there after she finishes drawing.

Specific Subject Questions Requiring Specific Answers

- a) If S asks "What type of figures are they?" say "Geometric designs."
- b) If S asks, "How big should I draw it?" say "Draw it as much like the figure as possible." This is the stock response for questions about how similar drawings should be to the figures.
- c) If S asks if she forgot something after you say "Don't forget to draw everything that you see," say: "The figures will get more difficult soon."
- d) If S draws a design and offers commentary about it such as "This is a triangle," or "All sides are equal," explain that she is scored on what she draws, and that she may erase. Also, write down the commentary on her sheet.

Recording Information That May Have Influenced Performance

- a) Record any pertinent notes or information that may have influenced the performance (e.g., macular degeneration, intention tremor).

2

Ask S to turn to the next blank page in their booklet and ensure that she does turn the page. Place the Benton display booklet so that the blank cardboard sheet just before design 1 for Form D faces the S. Before showing the first figure say:

4

Give 10 seconds of viewing time.

5

Before card 3 say:

7

If S omits the peripheral minor figure on card 3, say the following phrase again before card 4:

9

If S draws before 10 seconds or wants to redraw on a clean sheet, staple the additional $\frac{1}{2}$ sheet to the gray portion of the Participant's Booklet. Be sure to mark the upper right corner of the new sheet with a dash.

10

Take S's Participant Booklet after she is finished with the BVR test and turn to the second divider sheet.

1

I'm going to show you some cards, one at a time. On each card there are one or more figures. Your job is to study the card for 10 seconds, and then when the card is covered, you draw what you have seen. Any questions?

3

Please wait until the card is covered before you start drawing. When you are finished drawing, turn to the next page in your booklet.

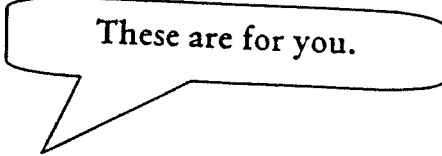
6

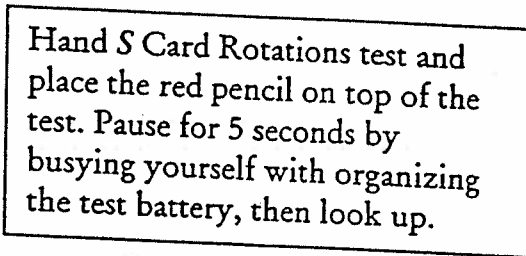
Please remember to draw everything you see.

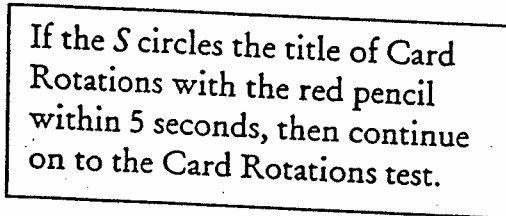
8

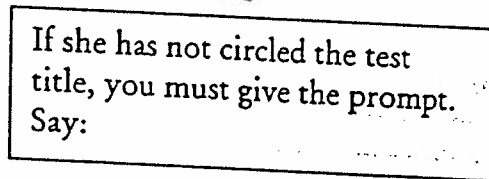
Remember to draw everything you see.

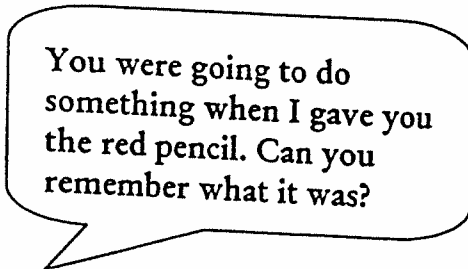
Prospective Memory #1: Remembering a Task

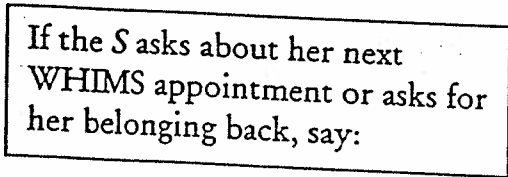
1  These are for you.

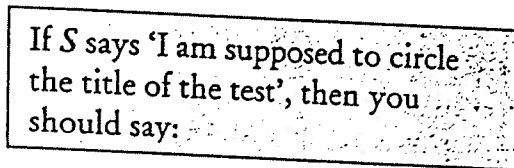
2  Hand S Card Rotations test and place the red pencil on top of the test. Pause for 5 seconds by busying yourself with organizing the test battery, then look up.

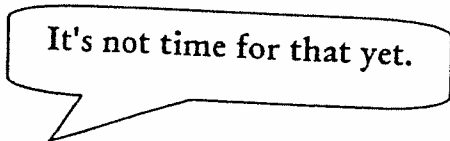
 If the S circles the title of Card Rotations with the red pencil within 5 seconds, then continue on to the Card Rotations test.

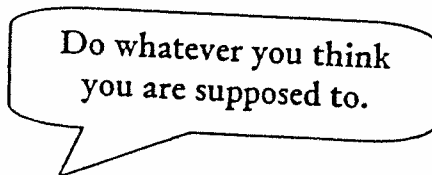
 If she has not circled the test title, you must give the prompt. Say:

 You were going to do something when I gave you the red pencil. Can you remember what it was?

 If the S asks about her next WHIMS appointment or asks for her belonging back, say:

 If S says 'I am supposed to circle the title of the test', then you should say:

 It's not time for that yet.

 Do whatever you think you are supposed to.

Prospective Memory #1: Remembering a Task Score Sheet

Record exactly what *S* spontaneously does or says (if anything): _____

Check here if the prompt is required: _____

Record response after the prompt (if given): _____

Scoring before a prompt: Choose one of the following

_____ 3 points

for spontaneously circling the title without the prompt.

_____ 2 points

for spontaneously remembering that a task was to be performed but *S* does not recall what exactly they must do. (e.g. The *S* may say 'I know I am supposed to do something with the red pencil, but I can't remember what').

_____ 2 points

for spontaneously remembering a task but does something other than circle the title. (e.g. The *S* underlines the title instead of circling it).

Scoring after a prompt:

_____ 1 point

for circling the title after the prompt, 'You were going to do something when I gave you the red pencil.' is given.

_____ 0 points

for incorrect response after the prompt.

_____ 0 points

for no response after the prompt.

Card Rotations

- 1) If *S* has difficulty rotating the triangles:
 - a) If the *S* has trouble seeing how the triangles at the top of the page can be rotated around into the different positions on the page, say: "See how the triangles at the top of the page can be rotated around into these different positions?" (rotate your hand around on the table to show *S* what you mean).
 - b) If *S* has trouble seeing that the 2 triangles below would have to be flipped over or made differently, say: "See how the triangles at the top of the page can be rotated around into these different positions?" (rotate your hand around on the table to show *S* what you mean). However, if you look at this triangle on the left (point to the triangle on the left, in the second set of triangles), no matter how much you rotate it around on the page, it will never fit completely over the other triangle. It would have to be flipped over to the other side to make it the same as the second triangle." (flip your hand over to demonstrate what you mean).
 - c) If the *S* still has difficulty seeing the difference between a rotation and a flip, use the cardboard triangle and actually show the *S* how the cardboard triangle can be rotated and flipped. Only use the cardboard triangle if demonstrating with your hand does not help.
- 2) If *S* makes errors on 2 of the first 3 practice figures, of the first practice line, stop her at that point and say: "I want you to notice that this figure has a jagged edge and a pointed edge (point out the jagged and pointed edge on the practice figure). You will want to use this to rotate the figures around on the page. You will also want to reevaluate the first three figures that you have already done to be sure that you still think that you responded correctly"
- 3) After the *S* is finished with the practice items, if she got any wrong (incorrectly marked either a 'S' or a 'D'), point out the ones that she got wrong. Say: "The correct answer for this one is _____. Ask her if she can now see the correction. If need be show her how to rotate the figure around to compare it to the target.
 - a) If the *S* circled a 'D' when she should have circled a 'S', say: "See how rotating this figure (the one she missed) into the same position as the target makes the two look the same." If the *S* can see her mistake, have her erase the 'D' and circle the 'S'. If the *S* has trouble seeing how this can be done you can actually draw what the figure would look like after the rotation has been made. If need be the rotation can be performed in two steps. This is especially helpful when the *S* has to make a 180° rotation in order to compare a figure to the target. First have the *S* make a 90° rotation (again you can draw what the figure would look like after making the 90° rotation), and then have the *S* make another 90° rotation to get it to the same position as the target (draw what the figure would look like after making the second 90° rotation).
 - b) If the *S* circled a 'S' when she should have circled a 'D' on the first row of practice items, say: "If you rotate this figure (the incorrect one) into the same position as the target figure, the jagged edge will be on the top, whereas with the target item the jagged edge is on the bottom. So, you would have to flip the figure over to get it to look like the target figure." If the error was made on the second row, say: "If you rotate this figure (the incorrect one) into the same position as the target figure, the flat edge would be on the left as it is with the target, but the part that sticks out would be top, rather than the bottom. So, you would have to flip the figure over to get it to look like the target figure." (Again, you can draw the figure if need be to help the *S* see the difference).
 - c) The cardboard triangle can also be used if a *S* is having extreme difficulty with the practice items. Again, only use the triangle if showing the *S* without the triangle does not help her to see the difference between a rotation and a flip of the figure.
- 4) If the *S* gets frustrated with the task you may encourage her to continue by saying: "This task is difficult and different from what most people are used to, so just do the best you can". Please do not let her quit the task simply because it is difficult.
- 5) If the *S* still does not understand the concept of rotating and flipping the figures after you have gone through all of the practice items and have shown her how to rotate and flip the items, say: "That's fine. Let's go on to another task." Write *S* *did not understand task* and mark with a discontinuation code on your Card Rotations sheet, and go on to the next task.

1

I am going to read aloud the instructions for this test while you read them to yourself. Ready?

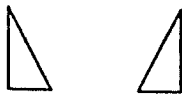
Read the instructions out loud while the S reads along.

This is a test of your ability to see differences in figures. Look at the 5 triangle-shaped cards drawn below.



All of these drawings are of the *same* card, which has been slid around into different positions on the page. Can you see that?

Now look at the 2 cards below.



These two cards are *not alike*. The first cannot be made to look like the second by sliding it around on the page. It would have to be *flipped over* or *made differently*. Can you see that?

Each problem in this test consists of one card on the left of a vertical line and eight cards on the right. You are to decide whether each of the eight cards on the right is the *same as* or *different from* the card at the left. Circle the S below the figure if it is the *same as* the one at the beginning of the row. Circle the D if it is *different* from the one at the beginning of the row.

Practice on the following rows. The first row has been marked correctly for you.

B										
		S	D	S	D	S	D	S	D	S
C										
		S	D	S	D	S	D	S	D	S
D										
		S	D	S	D	S	D	S	D	S

Your score on this test will be the number of items answered correctly minus the number answered incorrectly. Therefore, it will *not* be to your advantage to guess, unless you have some idea whether the card is the same or different. Work as quickly as you can without sacrificing accuracy.

You will have *3 minutes* for each of the two parts of this test. Each part has 1 page. Stop when you finish Part 1. Please do not go on to Part 2 until you are asked to do so.

S is given 3 minutes for each part.

2

S will already have the Card Rotations sheet. Ask S to do practice items; answer questions and, if necessary, teach S how to do the task. When S is ready to begin test, say:

3

Please turn the page and begin.

4

Take S's Participant Booklet after she is finished with Card Rotations and turn to the third divider.

Finger Tapping

Record the number of taps displayed at the end of each trial.

Be sure *S*'s other fingers do not rise off the board while she is tapping. She may hold her fingers down with her other hand if necessary. You may place your hand over her hand to prevent her fingers from moving.

Be sure *S* taps hard enough to advance the counter.

1 Place finger tapping machine in front of the *S* and say:

2 Now we are going to see how fast you can tap on this key with your index finger. Like this:

3 Demonstrate tapping for the *S*.

4 Let the key come all the way up and click each time you tap, or the counter will not advance. We're going to start with your dominant hand, the hand you write with.

5 Have the *S* indicate which is her dominant hand, and record on the data sheet.

6 Move the tapper to a comfortable position for your right/left hand. Put your right/left hand on the table and your index finger on the key. Keep the other fingers as flat as possible on the table while you are tapping. Only your index finger should move when you are tapping. Let's do a practice trial first. When you are ready begin tapping the key as fast as you can. The machine will display a number after 10 seconds. Stop tapping when you see that number. Begin when you are ready.

7 Allow 10 seconds per trial, and 15 seconds between trials. Record the number of counts for each trial. Continue for 7 trials, with a break of 30-60 seconds after the first 4 trials.

8 Let's take a short break.

9 Follow the same instructions as for the dominant hand. Record any information which may have influenced tapping speed - for example arthritis, long finger nails, etc.

10 Now you will use the index finger of your non-dominant hand. Let's do a practice trial first. Begin when you are ready.

Finger Tapping Score Sheet:

Subject's reported dominant hand: (R L) (circle one)

Part 1: Finger tapping dominant hand (R L) (circle one)

#taps trial 1 _____

#taps trial 2 _____

#taps trial 3 _____

#taps trial 4 _____ (take break after trial 4)

#taps trial 5 _____

#taps trial 6 _____

#taps trial 7 _____

Part 2: Finger tapping non-dominant hand (R L) (circle one)

#taps trial 1 _____

#taps trial 2 _____

#taps trial 3 _____

#taps trial 4 _____ (take break after trial 4)

#taps trial 5 _____

#taps trial 6 _____

#taps trial 7 _____

Information which might have influenced S's tapping speed:

California Verbal Learning Test - List A Long-Delay Free Recall

Time of Long-Delay Free Recall ①: _____ (hh:mm AM/PM)
(Record the time from your watch before beginning this part of the test)

Time of Short-Delay Cued Recall Completion ②: _____ (hh:mm AM/PM)
(Record the time that you recorded on page 13 from the Short-Delay Cued Recall sheet)

Total Delay (should be about 20 minutes): _____ (hh:mm)
(If the total delay is less than 17 minutes, take a short break to have the S stretch so that the delay is approximately 20 minutes. To calculate the total delay subtract ① - ②.)

It is very important that you keep track of the time between the end of the Short-Delay Cued Recall and the beginning of the Long-Delay Free Recall. If the total delay is consistently less than 17 minutes (ie., the delay for 3 or 4 subjects is less than 17 minutes), take a short break to have the S stretch so that the delay is approximately 20 minutes. If the total delay is consistently greater than 30 minutes, do the CVLT Long-Delay Free Recall, Long-Delay Cued Recall, and Long-Delay Recognition BEFORE Finger Tapping.

1

I read some shopping items to you earlier. I'd like you to tell me all the items you can from the Monday list - that was the first list, the one I read to you three times. Go ahead.

California Verbal Learning Test - List A Long-Delay Cued Recall

3

Tell me all of the shopping items from the Monday list that are: (category)

**List A
Long-Delay Cued
Recall Responses**

4

Clothing

6

Tools

5

Fruits

7

Spices and Herbs

California Verbal Learning Test - List A Long-Delay Recognition

8

I'm going to read a list of shopping items.
After I read each item, say 'Yes' if the item
was from the Monday list, and say 'No' if it
was not.

Was sweater on the Monday list?

Was oregano on the Monday list?

9

Continue for the 1st few items, then proceed with
just saying the item. Prompt when necessary.

Be sure to clearly enunciate each word on the list,
especially '*grill*' and '*chimes*'. If S says 'yes' to either
'*grill*' or '*chimes*' say:

That was '*grill*' with a 'g'.
or
That was '*chimes*' with an 'm'.

Record responses in the empty spaces to the right of
each item. For 'Yes' responses, put a 'Y' in the left
half of the space. For 'No' responses, put a 'N'
in the right half of the space.

Experimenter may spell item if necessary to be sure
S hears the item correctly.

10

List A Long-Delay Recognition			
	ITEM	Y	N
1	Sweater		
2	Oregano		
3	Flounder		
4	Rug		
5	Tires		
6	Pepper		
7	Jacket		
8	Aspirin		
9	Wax		
10	Drill		
11	Apricots		
12	Spatula		
13	Cherries		
14	Drums		
15	Chives		
16	Film		
17	Chisel		
18	Briefcase		
19	Pastry		
20	Tangerines		
21	Clock		
22	Shoes		
23	Grapes		
24	Salmon		
25	Paprika		
26	Racket		
27	Ginger		
28	Slacks		
29	Books		
30	Parsley		
31	Vest		
32	Apples		
33	Grill		
34	Plums		
35	Wrench		
36	Lemons		
37	Tapes		
38	Vitamins		
39	Pliers		
40	Bowl		
41	Hammer		
42	Nutmeg		
43	Chimes		
44	Soap		

Prospective Memory #2: Remembering an Appointment

1 We are half way through the test session.

2 Pause for 5 seconds. Again, busy yourself so that you don't cue the participant to remember the appointment

If she asks the appropriate question, proceed to *Verbal Fluency*.

If she does not ask the appropriate question within 5 seconds, you must give the prompt. Say:

You were going to ask me something when I said we were half way through the test session. Can you remember what it was?

If the S asks for her belonging back, say:

Again, if S says 'Am I supposed to ask you something?' you say:

It's not time for that yet.

Say whatever you think you are supposed to say.

Prospective Memory #2: Remembering next WHIMS appointment

Record exactly what S spontaneously does or says (if anything): _____

Check here if the prompt is required: _____

Record response after the prompt (if given): _____

Scoring before a prompt: Choose one of the following

- 3 points**
for spontaneously asking about the appointment without the prompt.
- 2 points**
for spontaneously remembering that she was supposed to remember something but S does not recall what exactly it was.
- 2 points**
for spontaneously remembering a task but does something other than ask the appropriate question.

Scoring after a prompt:

- 1 point**
for asking the appropriate question but after the prompt, 'You were going to ask me something.' is given.
- 0 points**
for incorrect response after the prompt.
- 0 points**
for no response after the prompt.

Verbal Fluency - FAS

1

Next, I am going to say a letter of the alphabet, and I want you to say, as quickly as you can, all the words you can think of which begin with that letter. You may say any words at all, except proper names such as the names of people or places, so you could not say 'Robert' or 'Rochester'. Also do not use the same word again, with a different ending, such as 'eat' and 'eating'.

For example, if I say 'B', you could say 'boy', 'book', 'blue', and so on. Can you think of other words beginning with the letter 'B'?

2

Wait for the *S* to give a word. If she succeeds, indicate to her that she is performing correctly, and ask her to give another word beginning with the letter 'B'. If she gives a second appropriate word, indicate that she is performing correctly and proceed to the test itself. If she gives an inappropriate word on either occasion, correct her and repeat the instructions. If she then succeeds, proceed to the test. If she fails to respond, repeat the instructions.

Write legibly.

If the *S* has succeeded in giving two appropriate words beginning with the letter 'B', then say:

4

Get the stopwatch ready to begin timing. Start the stopwatch immediately after you say 'Go' for each word.

3

That's fine, now I am going to give you another letter and again you say all the words beginning with that letter that you can think of. Remember, no names of people or places, just ordinary words. Also, if you draw a blank, I want you to keep trying until the time limit is up. You will have 1 minute for each letter.

Verbal Fluency - Fruits & Vegetables

1

Now we are going to do something a little different. This time I would like you to please name all the fruits as you can think of. So for the next 60 seconds, name all the fruits you can think of. Go.

2

This time please name all the vegetables you can think of. So for the next 60 seconds, name all the vegetables you can think of. Go.

Verbal Fluency - Notes

- (1) Any unusual words given by the *S* must be questioned / clarified after that trial is over.
- (2) If the *S* says words that begin with an incorrect letter or incorrect category, allow 2 consecutive errors before cueing the correct letter or category. After 2 of these errors simply repeat the appropriate letter or category.
- (3) If a word is given twice but may have two different spellings (e.g., forth & fourth), the *S* may get credit for both spellings. If the *S* says one right after the other, or says something like 'both forths', both should be counted. If the *S* says 'forth' early in the time interval then later says 'forth' without making reference to the previous 'forth', then say 'You said forth, could you please spell that for me?' - but only after the 60 second trial is complete. If *S* only makes reference to one of the 'forths', give the *S* credit for that 'forth' and count the other as a repeat.
- (4) *S* may give numbers. However, if *S* gives consecutive numbers (e.g., 50, 51, 52), *S* will get credit for the first two numbers (50, 51) but no additional numbers within that series. If *S* starts doing this, after the third consecutive number in a series say 'please go on to other words'.
- (5) Slang words are acceptable if in general use. Foreign words are acceptable if considered part of the English language - e.g. soirée, fête, siesta.
- (6) If *S* starts giving foreign words that are not in common usage in the English language (eg. fenêtre), say 'English words please', after the 2nd foreign word in a row.
- (7) If the *S* comments that she can not think of any more words before the 60 seconds are complete, say: 'You still have more time'.
- (8) If you are unsure of a word the *S* said, wait until the 60 second trial is over and say: 'You said _____, can you tell me more about that word, I am not familiar with it'. You may also want to ask the *S* to spell the word.
- (9) If a *S* gives a super-ordinate category (e.g. apples) and also gives exemplars of the category (e.g. red delicious, macintosh), the *S* gets credit for all three of the words. However, if the *S* says apple and apples, apples is considered a repeat.

Digit Span

Read digits at a rate of 1 per second in a loud, monotonic voice, dropping voice at the end of the string of digits.

Write down the numbers that the *S* says, in the order she says them. Record a *P* if *S* says the numbers correctly and an *F* if she says them incorrectly.

Do not let *S* know whether or not responses are correct. Discontinue after *S* misses both trials of the SAME number length.

S is allowed to change her response. If *S* changes her response on one of the items, write 'S changed mind' next to the correction.

Forward

1

Next, I am going to say some numbers. Listen carefully, and when I'm through, say them right after me.

Backward

3

Now I'm going to say some numbers, and this time when I stop I want you to say them backwards. For example, if I say 7-1-9 what would you say?

If *S* says 9-1-7, say

That's right.

Go on to Digits Backward

If *S* is incorrect, say

No, 9-1-7. I said, 7-1-9, so to say it backwards, you would say 9-1-7. Now try these numbers. Remember, you are to say them backwards. 3-4-8.

Give no feedback on '3-4-8'. Go on to Digits Backward whether or not *S* gets the second example correct.

2

Digits Forward		Subject's Response	Pass / Fail
(1)	5-8-2		
	6-9-4		
(2)	6-4-3-9		
	7-2-8-6		
(3)	4-2-7-3-1		
	7-5-8-3-6		
(4)	6-1-9-4-7-3		
	3-9-2-4-8-7		
(5)	5-9-1-7-4-2-8		
	4-1-7-9-3-8-6		
(6)	5-8-1-9-2-6-4-7		
	3-8-2-9-5-1-7-4		
(7)	2-7-5-8-6-2-5-8-4		
	7-1-3-9-4-2-5-6-8		

4

Digits Backward		Subject's Response	Pass / Fail
(1)	2-4		
	5-8		
(2)	6-2-9		
	4-1-5		
(3)	3-2-7-9		
	4-9-6-8		
(4)	1-5-2-8-6		
	6-1-8-4-3		
(5)	5-3-9-4-1-8		
	7-2-4-8-5-6		
(6)	8-1-2-9-3-6-5		
	4-7-3-9-1-2-8		
(7)	9-4-3-7-6-2-5-8		
	7-2-8-1-9-6-5-3		

Positive and Negative Affect Schedule

1

Give the S the PANAS

You may tell the S that this test is not timed.

After the S is finished with the PANAS, take the Participant's booklet away and check to ensure that she has not skipped any lines or circled more than 1 response in a row. If she has circled more than 1 response in a row, ask her to choose which response best reflects how she has felt during the past 2 weeks.

2

I am going to read the instructions for this questionnaire aloud while you read them to yourself.

Each word below describes a particular feeling. Circle the number that best shows how much each word describes the way you felt over the past two weeks. You can begin when you are ready

	Very Slightly	A little	Moderate	Quite a bit	Extremely
Interested	1	2	3	4	5
Distressed	1	2	3	4	5
Excited	1	2	3	4	5
Upset	1	2	3	4	5
Strong	1	2	3	4	5
Guilty	1	2	3	4	5
Scared	1	2	3	4	5
Hostile	1	2	3	4	5
Enthusiastic	1	2	3	4	5
Proud	1	2	3	4	5
Irritable	1	2	3	4	5
Alert	1	2	3	4	5
Ashamed	1	2	3	4	5
Inspired	1	2	3	4	5
Nervous	1	2	3	4	5
Determined	1	2	3	4	5
Attentive	1	2	3	4	5
Jittery	1	2	3	4	5
Active	1	2	3	4	5
Afraid	1	2	3	4	5

Geriatric Depression Scale

1

Read each statement out loud. Do not elaborate to interpret the questions. Periodically remind the S that these questions refer to how she has felt during the past week.

Check either 'Yes' or 'No' in the appropriate box as you go along.

2

Now I am going to ask you some questions about how you have felt, in general, during the *past week*. Please answer *yes* or *no*. OK?

Yes No

_____ _____ *During the past week...*
 _____ _____ Have you basically been satisfied with your life?
 _____ _____ Have you dropped many of your activities and interests?
 _____ _____ Have you felt that your life is empty?

_____ _____ *During the past week...*
 _____ _____ Were you often bored?
 _____ _____ Were you in good spirits most of the time?
 _____ _____ Were you afraid that something bad was going to happen to you?
 _____ _____ Were you happy most of the time?

_____ _____ *During the past week...*
 _____ _____ Did you often feel helpless?
 _____ _____ Did you prefer to stay at home, rather than going out and doing new things?
 _____ _____ Did you feel you had more problems with memory than most?

_____ _____ *During the past week...*
 _____ _____ Did you think it is wonderful to be alive?
 _____ _____ Did you feel pretty worthless?
 _____ _____ Did you feel full of energy?
 _____ _____ Did you feel that your situation is hopeless?
 _____ _____ Did you think that most people are better off than you are?

Prospective Memory #3: Remembering a Belonging

1

We have finished this test.

2

Pause for 5 seconds and busy yourself with stapling the Participant's Booklet to the back of this Test Administration Instruction Booklet. During this time pay attention to whether the S spontaneously asks for the belonging and gives its location verbally or by pointing.

Discontinue the test if she asks for the belonging and gives the correct location within 5 seconds.

If she has not remembered within 5 seconds, you must give the item prompt. Say:

You were going to remind me to give you something of yours.
Can you remember what it was?

Discontinue the test if she asks for the correct belonging and states the location of the belonging.

If she asks for the correct belonging but does not indicate the location then you must give the location prompt. Say:

Can you remember where I put it?

Prospective Memory #3: Remembering a Belonging Score Sheet

Record exactly what S spontaneously does or says (if anything): _____

Check here if the prompt is required: _____

Record response after the prompt (if given): _____

Scoring before a prompt: Choose one of the following

- _____ 3 points
for spontaneously remembering the belonging without the prompt.
- _____ 2 points
for spontaneously remembering that she was supposed to remember something but S does not recall what exactly the item was.
- _____ 2 points
for spontaneously remembering a task but does something other than ask about the belonging.

Scoring after a prompt:

- _____ 1 point
for asking for the appropriate item but after the prompt, 'You were going to remind me to give you something.' is given.
- _____ 0 points
for incorrect response after the prompt.
- _____ 0 points
for no response after the prompt.

Prospective Memory #3: Remembering the Location Score Sheet

Record exactly what S spontaneously does or says (if anything): _____

Check here if the prompt is required: _____

Record response after the prompt (if given): _____

Scoring before a prompt: Choose one of the following

- _____ 3 points
for spontaneously remembering where the belonging was without the prompt.
- _____ 2 points
for spontaneously remembering that she was supposed to remember where something was but S does not recall where exactly the item was.
- _____ 2 points
for spontaneously remembering a task but does something other than ask about the location of the belonging.

Scoring after a prompt:

- _____ 1 point
for remembering where the belonging was but after the prompt, 'Can you remember where I put it?' is given.
- _____ 0 points
for incorrect response after the prompt.
- _____ 0 points
for no response after the prompt.

Exit Procedure

Thank you very much for participating in this study.
Please don't discuss any of these tests with anyone,
particularly other participants in this study.

Please be sure to staple the Participant's Booklet to the back
of the Test Administration Instructions if you have not
already done so.

Was there anything that might have influenced the test results for this subject (e.g., hearing impairment, arthritis in hands, vision problem, tremor)?

NO

YES (please specify) _____
