ADVANCE PREVENTIVE
MEDICINE & URGENT CARE

Name: _____
Date of Birth: _____
Phone: _____
Insurance Name: _____

Cognitive Assessment

Have you ever experienced:

If Yes, please select how often below symptoms are occurring either daily, weekly, or monthly

• Sensation of not feeling right, being a little confused or unsteady?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Spells you would describe as feeling faint or as if you might pass out?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Events where you've experienced altered awareness?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly

Have you ever experienced:

If Yes, please select how often below symptoms are occuring either daily, weekly, or monthly

• Episodes of temporary confusion or brain fog?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Dizziness accompanied by loss of awareness or confusion?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Difficulty finding the right words or expressing yourself?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Lapse of time or zoning out?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Difficulty recalling the details of conversations you just had or TV shows you just watched?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly

Do you have history of:

• TBI (Traumatic Brain Injury)	☐ Yes	☐ No
• TIA (Transient Ischemic Attack/ Mini-Stroke)	☐ Yes	☐ No
• Brain concussion or Post-concussion Syndrome	☐ Yes	☐ No
• Dementia	☐ Yes	☐ No
• Stroke	☐ Yes	☐ No
• Brain injury, surgery, or tumors	☐ Yes	☐ No
• Migraines with Nausea, light sensitivity, or other aura	☐ Yes	☐ No

Physician/ Office Use Only:

Notes: _____

_____

_____

Onset: _____

_____

Patient Signature: _____ **Date:** _____