hdreach
Helping families with Huntington's disease

HD CLINIC FORM

Form completed by:
○ Patient
○ Companion at this visit

Patient Name:

Date of Birth:

This form can be shared with your medical provider before your visit or during. Or you may refer to it during discussions with your medical provider. You can keep a copy of this form in your own files for tracking purposes.

General Health and Well Being	Yes	No
Health and Well Being - Any changes to your health or well being since your last medical visit? If this is a first visit, please describe any health concerns for you or your loved one. Please also list any hospitalizations, visits to the ER, etc.		
Swallowing/Choking/Coughing - Are you having any trouble with foods or liquids?		
Weight Loss - Have you experienced any in the last 6-12 months? If yes, how much?		
Chorea - Any new or increased?		
If using, is chorea medication helping you?		
Falls - Have you had any in the last 6-12 months?		
Injuries - Have you experienced any in the last 6-12 months? If yes, please describe:		
Sleeping - Are you experiencing any difficulty falling asleep or staying asleep?		
Thinking Skills/Cognition – Have you noticed any changes? (Please list concerns.)		
Medical/Adaptive Equipment - Are you using any of the following? (check all that apply): ○ cane ○ walker ○ wheelchair ○ hospital bed ○ commode ○ shower bench/chair ○ raised toilet sear ○ grab bars ○ other		

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Mood/Behavior Symptoms	None	Mild	Moderate	Severe
Sadness/Depression				
Anxiety				
Perseveration (fixation on topics, repeating questions, difficulty moving past arguments)				
Irritability				
Anger outbursts or aggression				
Obsessional thoughts				
Compulsive behaviors				
Impulsiveness				
Apathy, lack of energy, difficulty initiating activities				
Suicidal thoughts – have you experienced any since your last medical visit? ○ None ○ Fleeting ○ Actively planning				

Health Questionnaire Over the last 2 weeks, how often have you been bothered by any of the following problems	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, hopeless				
Trouble falling or staying asleep				
Sleeping too much				
Feeling tired or having little energy				
No interest in eating or eating too much				
Feeling bad about yourself or feeling like a failure				
Trouble concentrating on things such as what you're reading or watching				
Moving or speaking so slowly that other people have noticed				
Being fidgety or restless and moving more than usual				
Thoughts that you would be better off dead, or thoughts of hurting yourself				
Have any of these issues made it difficult for you to do your work, take care of things at home, or get along with other people?				

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Care Partner Concerns	Yes	No
Health and Well Being – any changes to your health and well being since you last saw your physician?		
Isolation – Do you have the time and ability to see friends and socialize outside of your caregiving responsibilities?		
Information – Do you have access to the information you need to feel confident in your care giving ability?		
Resources – Do you feel you have access to information/counselors to help you make financial decisions and plan for the future?		
Sleep – are you able to get 6-8 hours of sleep most nights?		
Nutrition – are you able to eat meals on a regular schedule?		
Exercise – are you able to do some physical exercise each day?		
Physical ability – do you feel physically confident in your ability to assist your loved one with activities of daily living?		
Safety – has the irritability or aggression of your loved one made you feel unsafe or caused concern for the safety of others including your children?		
Privacy – Would you like to discuss questions or concerns with a doctor or social worker privately without your loved one present?		
Finances – Do you worry about being able to meet normal monthly living expenses?		
Basic Needs – Do you worry about food and housing?		