



University of Pittsburgh  
Alzheimer Disease Research Center

Participant Application

Date \_\_\_\_\_

**Applicant Information:**

Name: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip

Telephone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Work Cell

Age: \_\_\_\_\_ Gender:  Male  Female Highest grade or degree completed: \_\_\_\_\_

**Study Partner - a family member or friend who will accompany applicant to visit (required):**

Name: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip

Telephone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Work Cell

Relationship to applicant: \_\_\_\_\_

How much contact/time spent with the applicant: \_\_\_\_\_

**Person Completing Application (check one):**

Applicant  Study Partner  Other (if *Other* please complete contact information below):

Name: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip

Telephone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Work Cell

Relationship to applicant: \_\_\_\_\_

How much contact/time spent with the applicant: \_\_\_\_\_



Participant Application

Why does the applicant want to come to the Alzheimer Disease Research Center (ADRC)?

Two horizontal lines for text entry.

How did you learn about the ADRC? \_\_\_\_\_

Is the applicant experiencing memory or thinking problems? [ ] Yes [ ] No

If "Yes," briefly describe symptoms:

Two horizontal lines for text entry.

Has the applicant ever had an evaluation for memory or thinking? [ ] Yes [ ] No [ ] Don't know

If "Yes," When: \_\_\_\_\_ Where: \_\_\_\_\_

Was a diagnosis given? [ ] Yes [ ] No [ ] Don't know

If "Yes," what was the diagnosis? \_\_\_\_\_

A major focus of the ADRC is to match applicants with opportunities to volunteer for additional research studies related to Alzheimer's disease based on their interests and the eligibility requirements of the research. Which of the following types of research is there an interest in learning more about? (check all that apply)

- [ ] Brain Imaging (MRI, PET, etc.) [ ] Interviews/Questionnaires
[ ] Brain Donation/Autopsy Program [ ] Treatment Trials (e.g., medication or exercise)
[ ] Family/Caregiver Studies [ ] Genetic Studies

Applicant Demographic Information:

Present living arrangement: (check one)

- [ ] Alone [ ] Spouse/Partner [ ] Other Relative [ ] Retirement Community
[ ] Assisted Living [ ] Nursing Facility [ ] Other (specify) \_\_\_\_\_

Ethnicity - Hispanic/Latino? [ ] Yes [ ] No

Race: (check all that apply)

- [ ] American Indian or Alaska Native [ ] Asian [ ] Native Hawaiian or Other Pacific Islander
[ ] Black or African American [ ] White [ ] Other

Native Language: (check one) [ ] English [ ] Other (specify): \_\_\_\_\_

If native language is other, age when applicant learned English: \_\_\_\_\_



## Participant Application

### Memory, Thinking, Behavior, and Functional Information:

Please use the following scale to indicate the answer to each question about the applicant:  
(Circle one number on each line)

	Always	Usually	Sometimes	Rarely	Never	Don't know
Does applicant...						
...recognize the faces of family and friends?	0	1	2	3	4	9
...remember the names of family and friends?	0	1	2	3	4	9
...remember her/his address or telephone number?	0	1	2	3	4	9
...remember what day or month it is?	0	1	2	3	4	9
...remember where things are usually kept?	0	1	2	3	4	9
...seem confused?	0	1	2	3	4	9
...make sense in conversation?	0	1	2	3	4	9
Is applicant able to write her/his name?	0	1	2	3	4	9
Has applicant heard sounds or voices or seen things that no one else can hear or see?	0	1	2	3	4	9
Is applicant agitated or aggressive?	0	1	2	3	4	9
Is applicant currently depressed?	0	1	2	3	4	9

Please rate the applicant's ability to perform the following activities, by checking (✓) the appropriate box:

	Able to do independently	Needs prompts and/or reminders	Needs assistance to do	Unable to do	Does not apply	Don't know
Using the telephone						
Shopping						
Cooking/food preparation						
Household chores/minor repairs						
Laundry						
Managing medications						
Managing money/handling finances						
Bathing/personal grooming						
Dressing (including selecting clothing)						
Going to the bathroom						
Taking part in activities outside the home						



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**Medical Conditions:**

Please indicate whether the applicant has any of the following conditions.

Mark 'Yes' or 'No' and then add any additional information or details you'd like us to know.

<b>Medical Conditions</b>	<b>No</b>	<b>Yes</b>	<b>Additional Info</b>
Heart Attack (Myocardial Infarction / "Coronary")	<input type="checkbox"/>	<input type="checkbox"/>	
Open heart surgery What type? (Stent, Bypass, Valve replacement, etc.) _____	<input type="checkbox"/>	<input type="checkbox"/>	
Congestive heart failure, heart failure	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure / Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Elevated cholesterol and/or triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes / "sugar" / High blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke / brain hemorrhage / or brain embolism	<input type="checkbox"/>	<input type="checkbox"/>	
TIA (transient ischemic attack / "ministroke")	<input type="checkbox"/>	<input type="checkbox"/>	
Brain surgery What type? (Aneurysm, Repair, Tumor removal, etc.) _____	<input type="checkbox"/>	<input type="checkbox"/>	
Head injury where the applicant lost consciousness (i.e., was "knocked out") When? _____ How long was the applicant unconscious? _____	<input type="checkbox"/>	<input type="checkbox"/>	
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer in the last 5 years What type? _____	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatoid arthritis or Lupus	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney disease or kidney dialysis	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure disorder / Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
HIV (Human immunodeficiency virus) or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
Leukemia or other blood diseases What type? _____	<input type="checkbox"/>	<input type="checkbox"/>	



