



# NEUROPSYCHIATRIC INVENTORY QUESTIONNAIRE



ID  
NUMBER:

FORM CODE: NPI

DATE: 04/01/2016  
Version 1.0

## ADMINISTRATIVE INFORMATION

0a. Completion Date: //  
Month Day Year

0b. Staff ID:

**Instructions:** This form is administered to the informant. {S} refers to subject, please state subject's name where {S} is found below. The following questions are based upon changes in neuropsychiatric symptoms over the previous month.

**Script:** "Now I will ask you questions about your husband/ wife/ brother/ sister/ parent/ friend's behavior and personality."

### Severity

|                                                                                                                                                                                                              | Yes                                       | No                                    | Mild                                      | Moderate                              | Severe                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------|-------------------------------------------|---------------------------------------|---------------------------------------|
| 1. DELUSIONS:<br>Does {S} believe that others are stealing from him or her, or planning to harm him or her in some way?                                                                                      | 1a. <input type="checkbox"/> <sub>Y</sub> | <input type="checkbox"/> <sub>N</sub> | 1b. <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| 2. HALLUCINATIONS:<br>Does {S} act as if he or she hears voices? Does he or she talk to people who are not there?                                                                                            | 2a. <input type="checkbox"/> <sub>Y</sub> | <input type="checkbox"/> <sub>N</sub> | 2b. <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| 3. AGITATION OR AGGRESSION:<br>Is {S} stubborn and resistive to help from others?                                                                                                                            | 3a. <input type="checkbox"/> <sub>Y</sub> | <input type="checkbox"/> <sub>N</sub> | 3b. <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| 4. DEPRESSION OR DYSPHORIA:<br>Does {S} act as if he or she is sad or in low spirits? Does he or she cry?                                                                                                    | 4a. <input type="checkbox"/> <sub>Y</sub> | <input type="checkbox"/> <sub>N</sub> | 4b. <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| 5. ANXIETY:<br>Does {S} become upset when separated from you? Does he or she have any other signs of nervousness, such as shortness of breath, sighing, being unable to relax, or feeling excessively tense? | 5a. <input type="checkbox"/> <sub>Y</sub> | <input type="checkbox"/> <sub>N</sub> | 5b. <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |

**Severity**

|                                                                                                                                                                                                   | Yes                                        | No                                    | Mild                                       | Moderate                              | Severe                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------|--------------------------------------------|---------------------------------------|---------------------------------------|
| 6. ELATION OR EUPHORIA<br>Does {S} appear to feel too good or act excessively happy?                                                                                                              | 6a. <input type="checkbox"/> <sub>Y</sub>  | <input type="checkbox"/> <sub>N</sub> | 6b. <input type="checkbox"/> <sub>1</sub>  | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| 7. APATHY OR INDIFFERENCE:<br>Does {S} seem less interested in his or her usual activities and plans of others?                                                                                   | 7a. <input type="checkbox"/> <sub>Y</sub>  | <input type="checkbox"/> <sub>N</sub> | 7b. <input type="checkbox"/> <sub>1</sub>  | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| 8. DISINHIBITION:<br>Does {S} seem to act impulsively? For example, does the patient talk to strangers as if he or she know them, or does the patient say things that may hurt people's feelings? | 8a. <input type="checkbox"/> <sub>Y</sub>  | <input type="checkbox"/> <sub>N</sub> | 8b. <input type="checkbox"/> <sub>1</sub>  | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| 9. IRRITABILITY OR LABILITY:<br>Is {S} impatient or cranky? Does he or she have difficulty coping with delays or waiting for planned activities?                                                  | 9a. <input type="checkbox"/> <sub>Y</sub>  | <input type="checkbox"/> <sub>N</sub> | 9b. <input type="checkbox"/> <sub>1</sub>  | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| 10. MOTOR DISTURBANCE:<br>Does {S} engage in repetitive activities, such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?                         | 10a. <input type="checkbox"/> <sub>Y</sub> | <input type="checkbox"/> <sub>N</sub> | 10b. <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| 11. NIGHTTIME BEHAVIORS:<br>Does {S} awaken you during the night, rise too early in the morning or take excessive naps during the day?                                                            | 11a. <input type="checkbox"/> <sub>Y</sub> | <input type="checkbox"/> <sub>N</sub> | 11b. <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| 12. APPETITE AND EATING:<br>Has {S} lost or gained weight, or had a change in the food he or she likes?                                                                                           | 12a. <input type="checkbox"/> <sub>Y</sub> | <input type="checkbox"/> <sub>N</sub> | 12b. <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |