



Welcome to our Recode program here at TLC: The Littleton Clinic!

This sheet is designed to help explain what our program does and instructions to help you on your journey to reverse and prevent cognitive decline. This is a comprehensive program in which Dr. Hopp follows the Bredesen Protocol, designed and tested by Dr. Dale Bredesen. It is a systematic approach proven to reverse cognitive decline. Single medications do not work, every clinical trial testing these medications has failed. We will evaluate your risk factors and make lifestyle recommendations in terms of diet, exercise, stress, nutrition, sleep, social interaction and supplements.

Listed below are instructions and what to expect:

1. The first step is to sign up for the ReCODE Report program through AHNP Precision Health. This can be found by going to the link: <https://www.ahnphealth.com/>.
2. Once you have signed up for the ReCODE Report, schedule an initial appointment with Dr. Hopp.
3. PRIOR to your appointment, fill out our New Patient Packet along with MyCog and TheirCog questionnaires.
4. The initial appointment will consist of gathering history, physical and ordering labs. Some supplements will be started. Diagnostic tests will be ordered.
5. Schedule appointments with our Health Coach to review the Ketoflex diet, exercise protocols, brain exercises, meditation and social interaction recommendations. Health coaching is not covered by insurance but is an important part of our program.
6. At the second appointment labs and test results will be reviewed. Updates with lifestyle modification will be assessed. The supplements will be refined. If necessary, further diagnostic tests will be ordered.
7. Our Health Coach will continue to help you through the protocol.

Cognitive Questionnaire – MyCog

For patient to fill out

Name:

Age:

Date:

a) Do you perceive memory or cognitive difficulties? YES NO

b) Would you ask a doctor about these difficulties? YES NO

c) In the last two years, has your cognition or memory declined? YES NO

Below is a list of activities. Please answer YES if you believe you perform them WORSE than roughly two years ago.

1. I find it harder to learn new telephone numbers. YES NO

2. I find it harder to find personal possessions (keys, telephone, utensils, etc.). YES NO

3. I find it harder to describe the plots of films. YES NO

4. I find it harder to remember doctor's appointments. YES NO

5. I find it harder to follow the plot of a book. YES NO

6. I'm worse at recalling the details of a recent family event. YES NO

7. I find it harder to remember the result of a recent sporting event. YES NO

8. I find it harder to remember sums of money (payments or debts). YES NO

9. I find it harder to remember the details of a conversation. YES NO

10. I find it harder to remember things without using strategies (lists, diary, etc.). YES NO

11. I find it harder to remember the details of recent news. YES NO

12. I find it harder to remember famous people's names. YES NO

13. I find it harder to remember the names of people I've met recently. YES NO

14. I find it harder to remember street and city names. YES NO

15. I'm worse at finding the word I want to use in a conversation. YES NO

16. I find it harder to understand things the first time someone says them. YES NO

17. I find it harder to remember the names of places I've visited recently. YES NO

18. I find it harder to concentrate on what I am doing. YES NO

19. I'm worse at planning things that aren't part of my daily routine (travel, excursions, etc.). YES NO

20. I find it harder to use electronic devices. YES NO

21. I find it harder to start new or different things. YES NO

22. I find it harder to start conversations. YES NO

23. I find it harder to do mental arithmetic. YES NO

24. I find it harder to do more than one thing at once without getting agitated. YES NO

TOTAL NUMBER "YES": _____

Reversing Cognitive Decline Questionnaire – Relative’s Perspective

Filled out by relative or close friend

Patient’s Name _____

Your Name _____

Date of Birth _____

Date _____

1. Does your loved one have memory loss?*

Yes No

2. If you answered yes to question 1, is their memory worse than it was a few years ago?

Yes No

3. Do they repeat statements or stories in the same day?*

Yes No

4. Have you had to take over tracking events or appointments, or does the patient forget appointments?

Yes No

5. Do they misplace items more than once a month?

Yes No

6. Do they suspect others of hiding or stealing items when they cannot find them?

Yes No

7. Does your loved one frequently have trouble knowing the day, date, month, year, and time; or check the date more than once a day?*

Yes No

8. Do they become disoriented in unfamiliar places?

Yes No

9. Do they become more confused when not at home or while traveling?

Yes No

10. Excluding physical limitations, do they have trouble handling money, such as tips or calculating change?

Yes No

11. Do they have trouble paying bills or doing finances?*

Yes No

12. Do they have trouble remembering to take medicines or keeping track of medications taken?

Yes No

13. Does your loved one have difficulty driving; or are you concerned about their driving?

Yes No

14. Are they having trouble using appliances such as the stove, phone, remote control, or microwave?

Yes No

15. Excluding physical limitations, are they having difficulty completing home repair or housekeeping tasks?

Yes No

16. Excluding physical limitations, have they given up or cut down on hobbies or crafts?

Yes No

17. Are they getting lost in familiar surroundings, such as their own neighborhood?*

Yes No

18. Is their sense of direction failing?

Yes No

19. Do they have trouble finding words other than names?

Yes No

20. Do they confuse names of family members or friends?*

Yes No

21. Do they have trouble recognizing familiar people?*

Yes No

Total points = _____