Capacity Worksheet for Lawyers – Self Assessment

Attorney: ______________________________  Date: _________________

This is not a diagnostic tool. This self-assessment is designed as a starting point to assist lawyers who may have concerns about their current cognitive functioning. A thorough assessment by a qualified professional is recommended if you have concerns about your findings. If you need assistance with a referral to a qualified professional, please contact The Mississippi Bar Lawyers and Judges Assistance Program. When following up with a professional, you are encouraged to provide this assessment.

As you consider the following, pay special attention to significant changes in your functioning over time. Have you recently noticed, or have those around you observed marked changes. Check all that apply, and indicate specific examples. Use the additional comments section to cite other examples as needed.

Do you have concern(s) about your functioning personally or professionally? Yes / No

If yes, please identify the concern(s,) and offer any thoughts as to possible cause(s.)

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Have others expressed concern(s) about your functioning personally or professionally? Yes / No

If yes, please identify who has expressed concern(s,) and what concern(s) were expressed.

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What are your thoughts about the concern(s) expressed?

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____________________________________________________________________________
Cognitive Functioning

Short-term Memory Problems ______

_____ Repeating questions frequently
_____ Forgetting what is discussed within 15-30 min
_____ Inability to remember/recall events of past few days

Additional comments:
________________________________________________________________________
________________________________________________________________________

Language/Communication Problems ______

_____ Difficulty finding words frequently
_____ Using uncharacteristically vague language
_____ Experiencing difficulty staying on topic
_____ Disorganized
_____ Unusual statements or reasoning

Additional comments:
________________________________________________________________________
________________________________________________________________________

Comprehension Problems ______

_____ Difficulty repeating simple concepts
_____ Repeated questioning

Additional comments:
________________________________________________________________________
________________________________________________________________________
Lack of Mental Flexibility ______

- Difficulty comparing alternatives
- Difficulty adjusting to changes

Additional comments:

__________________________________________________________________________

__________________________________________________________________________

Calculation/Financial Management Problems ______

- Difficulty with previously familiar mathematical operations
- Difficulty with billing process
- Difficulty paying bills and managing office or personal finances

Additional comments:

__________________________________________________________________________

__________________________________________________________________________

Disorientation ______

- Trouble navigating office or other familiar work environments; getting lost in familiar areas
- Confusion about day/time/year/season

Additional comments:

__________________________________________________________________________

__________________________________________________________________________
Emotional Functioning

Emotional Distress _____

_____ Anxiety
_____ Depressed mood
_____ Tearful/distressed
_____ Excited/pressured/manic
_____ Uncharacteristic anger
_____ Seemingly misplaced/misdirected anger
_____ Emotional lability
Moving quickly between emotions (ex. - laughter to tears)
Experiencing emotions inconsistent with situation (ex. – smiling at sad news)

Additional comments:
______________________________________________________________________________
______________________________________________________________________________

Behavioral Functioning / Examples

Delusions _____
_____ Feel others out “to get” you or spying/organizing against you
_____ Feel persecuted
_____ Fearful, feel unsafe

Hallucinations _____
_____ Hearing, seeing, or otherwise interacting with stimuli others can’t see or hear

Poor Grooming/Hygiene _____
_____ Lack of attention to appearance (unusually unclean/unkempt)
_____ Inappropriate dress

Additional comments:
______________________________________________________________________________
______________________________________________________________________________
Mitigating/Qualifying Factors

Stress, grief, depression, recent events affecting you:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Medical factors / conditions

_____ Sensory functioning (hearing / vision loss)
_____ Family history of dementia
_____ Substance abuse / dependence
_____ Hypertension
_____ Stroke history
_____ Thyroid disease
_____ Chemotherapy
_____ Sleep apnea
_____ Prescription medications
_____ High cholesterol

Additional:
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Other Comments/Considerations
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______________________________________________________________________________
______________________________________________________________________________
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