**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**QUESTIONNAIRE**

**Section 1 – Personal Information**

Client’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_

Nickname/Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s home? \_\_\_\_\_ Family/Friend home?\_\_\_\_\_ Facility?\_\_\_\_\_ Other?\_\_\_\_\_

If facility was checked, please provide facility name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (if able to use)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Alzheimer’s Diagnosis (approx.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2 – Contact/Emergency Contact Information**

Primary Contact:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact preference: Phone\_\_\_\_\_ Text\_\_\_\_\_ Email\_\_\_\_\_

Secondary Contact

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact preference: Phone\_\_\_\_\_ Text\_\_\_\_\_ Email\_\_\_\_\_

Other Contacts (optional)

**Section 3 – Caregiver**

Primary Caregiver

Primary Contact\_\_\_\_\_ Secondary Contact\_\_\_\_\_

If not the Primary or Secondary Contact, please provide the name and contact details for the client’s caregiver(s)



Is the client receiving any therapy or home health services? Yes\_\_\_\_\_ No\_\_\_\_\_

(If yes, please provide the agency name and phone number(s))



**Section 4 – Safety**

Does the client have or wear any special safety devices such as Medic Alert devices?

(If yes, please describe the type of device and company)



Safety is one of our primary concerns. If there are any safety issues such as wandering or behavioral issues that you are willing to share to help us provide the safest experience, please list here



**Section 5 – Client’s Preferences and Needs**

Does the client need any physical help with daily activities? (if yes, please describe the type and amount of help needed)



Does the client use any type of assistive devices for walking/mobility such as canes, walkers or wheelchairs? (If yes, please provide what type of device and if the client has them available or if they have to be provided)

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Does the client need any type of brace, prosthetic or orthotic for daily use? (If yes, please briefly describe the type)



Does the client need any special assistive devices for dressing, bathing or eating? (If yes, please briefly describe what devices are needed)



Are there any food preferences, allergies or precautions we should know about?



Are there any special instructions we/caregivers should know to help us get to know or work with the client or make it easier to care for the client?



Tell us about some of the client’s favorites (for example, food, activities, places, books etc.)



Are there any other needs/preferences that we/caregivers should know about the client?

