Client Number:_____ **Client Startup Date:** _____

PROJECT LIFESAVER HENDRICKS COUNTY, INC.

Personal Data Questionnaire

This form is designed to provide Client information that will be useful to Project Lifesaver team members and search teams should the need arise. Providing this information, in advance, will assist team members in providing a more effective response, should the Client go missing?

Please complete this form to the best of your ability. If additional space is needed, feel free to write in the margins or add additional pages as necessary.

Client Information:

Client Name: _____ _____
First *Middle* *Last* *Nickname*

Primary Diagnosis: _____ Date of Birth: _____

Gender: *Male Female* Ethnicity: _____ Skin Complexion: *Light Medium Dark*
(Circle) *(Circle One)*

Mental Capacity (Age): _____ Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____ Hair Style: _____

Balding? *Yes No* Sideburns? *Yes No* Facial Hair? *Yes No* _____
(If Yes, then describe)

Weight: _____ Build: *Thin Muscular Heavy* False Teeth? *Yes No*
(Circle One)

Distinguishing Features: _____
(Marks, Scars, Tattoos, Etc.)

General Appearance: *(Anything additional - not covered above)* _____

_____

Client's Residence:

Home Address: ____
Street *Town*

Zip Code: __________ County: __________________ Township: __________________

Home Phone: __________________ Subdivision Name: __________________________

Fenced yard? *Yes* *No* Nearby pool or retention pond? *Yes* *No* ______________________
(If Yes, Where?)

Other pertinent info about the home: ____________________________________

Caregiver Information:

Caregiver 1

Name: __________________________________ Relation to Client: ________________

Address: ____
Street Town Zip

Primary Phone: ________________________ Alternate Phone: ______________________

Email address: ____

Caregiver 2

Name: __________________________________ Relation to Client: ________________

Address: ____
Street Town Zip

Primary Phone: ________________________ Alternate Phone: ______________________

Email address: ____

Caregiver 3 *(if applicable)*

Name: __________________________________ Relation to Client: ________________

Address: ____
Street Town Zip

Primary Phone: ________________________ Alternate Phone: ______________________

Email address: ____

Client/Caregiver Preliminary Questions:

Circle One

Is the Client continuously supervised? (A caretaker is present 24 hours a day, 7 days a week) *Yes* *No*

Will the Client be willing to wear a wrist transmitter at all times? *Yes* *No*

- If No, will the Client be willing to wear an ankle transmitter at all times? *Yes* *No*

Are you, as the caregiver, willing to abide by the requirements of the program? *Yes* *No*

Do you agree to explain the program to all 'temporary' caregivers and confirm that they understand and are willing to abide by the program requirements? *Yes* *No*

Client Background & Routine:

Does the Client attend school or other supervised care program outside the home? *Yes* *No*

If yes, please complete the following:

School / Program Name:

Facility Address: _____

Phone: _____ How long have they attended? _____

General Schedule: Sun. Mon. Tue. Wed. Thu. Fri. Sat.

Teachers Name: _____ Email: _____

How is client transported: _____

Does the Client have a history of aggressive or violent behavior? *Yes* *No*

Does the Client presently operate a motor vehicle? *Yes* *No*

Most recent place of employment: *(if applicable)* _____

Most recent occupation: *(if applicable)* _____

Communication:

Is the Client able to communicate? *Yes* *No* Is the Client able to read? *Yes* *No*

Client can: *Speak* *Write* *Sign* *Mute* *Deaf* *Other:* _____
(Circle all that apply) *(Explain)*

Does the Client speak English? *Yes* *No* If No, what language is understood? _____

Does the Client regularly wear Glasses? *Yes* *No* Contacts? *Yes* *No* Sunglasses? *Yes* *No*

If Yes to any of the above, please describe: _____

What degree of vision does the Client have without eyewear? *Good* *Fair* *Poor* *None*
(Circle One)

Does the Client wear a hearing aid? *Yes* *No* If so, what style? _____

What degree of hearing does the Client have without an Aid? *Good* *Fair* *Poor* *None*
(Circle One)

Does the Client wear a watch or any other jewelry on the wrist? *Yes* *No* Necklace? *Yes* *No*

Client Medical History:

Please list any major medical conditions:

Medical Condition 1: _____

Description: _____

Medical Condition 2: _____

Description: _____

Medical Condition 3: _____

Description: _____

Medical Condition 4: _____

Description: _____

Medical Condition 5: _____

Description: _____

Medications: *(Please list all Long-Term prescriptions)*

Rx 1: _____ Dosage: _____

Condition that Rx 1 is prescribed? _____

Consequences of **NOT** taking Rx 1: _____

Rx 2: _____ Dosage: _____

Condition that Rx 2 is prescribed? _____

Consequences of **NOT** taking Rx 2: _____

Rx 3: _____ Dosage: _____

Condition that Rx 3 is prescribed? _____

Consequences of **NOT** taking Rx 3: _____

Rx 4: _____ Dosage: _____

Condition that Rx 4 is prescribed? _____

Consequences of **NOT** taking Rx 4: _____

Rx 5: _____ Dosage: _____

Condition that Rx 5 is prescribed? _____

Consequences of **NOT** taking Rx 5: _____

Physicians:

Physician 1: _____ Phone: _____

Physician Type: _____

Physician 2: _____ Phone: _____

Physician Type: _____

Physician 3: _____ Phone: _____

Physician Type: _____

Does the Client have mobility problems? *Yes* *No* *(If Yes, describe)* _____

Does the Client use mobility assistance? *Yes* *No* *(If Yes, describe)* _____

Does the Client carry any Identification? *Yes* *No* *(If Yes, where)* _____

Personal Items Normally Carried by the Client:

Candy or Gum? *Yes* *No* *(Type & Brand)* _____

Tobacco Products? *Yes* *No* *(Type & Brand)* _____

Matches or Lighters? *Yes* *No* *(Type & Brand)* _____

Food Items? *Yes* *No* *(Type & Brand)* _____

Handbag, Purse, or Wallet? *Yes* *No* *(Describe)* _____

Other Pocket or Purse items? _____

Does the Client Typically carry - *Cash?* *Checkbook?* *Credit Card?*
(Circle all that apply)

Any other items typically carried? _____

Client Experience:

Is the Client familiar with the area? *Yes* *No* Length of residence? _____

If not local, what other areas are known by the Client? _____

Has the Client . . .

- been involved with Scouting? *Yes* *No* Explain: _____
- had First Aid training? *Yes* *No* Explain: _____
- had outdoor survival training? *Yes* *No* Explain: _____
- ever been lost before? *Yes* *No* - When & Where: _____

Was the Client found or did they come back on their own? _____

Location found: _____ Other pertinent information: _____

Does the Client . . .

- have previous Military experience? *Yes* *No* Explain: _____
- have outdoor recreational experience? *Yes* *No* Explain: _____
- overnight camping experience? *Yes* *No* Explain: _____
- ever go out alone? *Yes* *No* Explain: _____

What preventative measures have been taken in the home to prevent the client from wandering? _____

_____

Through experience, is there a "most effective" way to approach the Client? *Yes* *No*

If *Yes*, Please explain: _____

If Alzheimer's disease or Dementia has been diagnosed, answer the following:

When was the Client diagnosed? _____ Name of Spouse? _____ Living / Deceased

What is the best way to communicate with the Client? _____

Does the Client remain oriented to Time and Person? *Yes* *No* *(Explain)* _____

Does the Client recognize familiar people? *Yes* *No* *(Explain)* _____

Can the Client travel to familiar locations? *Yes* *No* *(Explain)* _____

Does the Client have a decreased knowledge of current events or tend to re-live past events? *Yes* *No*

(Explain) _____

Does the Client remember his/her own name and the names of spouse and/or children? *Yes* *No*

(Explain) _____

Does the Client suffer from delusions (See imaginary visitors, claim that their spouse / family are imposters, etc)? *Yes* *No* *(Describe)* _____

If Autism or Down syndrome has been diagnosed, answer the following:

When was the Client diagnosed? _____

What is the best way to communicate with the Client? _____

Does the Client have unusual reactions to sensory environment (touch, sound, bright lights, odors, and / or animals)? *Yes* *No* *(Describe)* _____

Does the Client engage in self-stimulatory behavior? (hand-flapping, finger flicking, rocking, spinning, or or shaking parts of their body)? *Yes* *No* *(Describe)* _____

Is the Client attracted to water? *Yes* *No* Does the Client know how to swim? *Yes* *No*

Is the Client insensitive to pain? *Yes* *No* Does the Client react differently to foods? *Yes* *No*

What foods would they - react well to? _____ react negatively to? _____

Does the Client have trouble with direct eye contact? *Yes* *No*

Does the Client dart away from you unexpectedly (bolt and run)? *Yes* *No*

Family & Friend Information: *(Other people the Client may try to contact)*

Name: _____ Relation: _____

City: _____ State: _____

Name: _____ Relation: _____

City: _____ State: _____

Name: _____ Relation: _____

City: _____ State: _____

Name: _____ Relation: _____

City: _____ State: _____

Name: _____ Relation: _____

City: _____ State: _____

Personality & Habits:

Does the Client . . .

- know/respond to his/her own name? *Yes* *No* *(Explain)* _____
- sometimes dress 'improperly'? *Yes* *No* *(Explain)* _____
- suffer from frequent personality and/or emotional changes? *Yes* *No* *(Describe)* _____
- wear a medical ID bracelet or other device to identify disability? *Yes* *No* *(Describe)* _____
- wear a "Safe Return" bracelet? *Yes* *No* *(Describe)* _____
- show evidence of Leadership? *Yes* *No* *(Describe)* _____
- have difficulty judging personal space? *Yes* *No* *(Describe)* _____
- swim or participate in water based activities? *Yes* *No* *(Explain)* _____
- drink Alcohol or use illicit drugs? *Yes* *No* *(Explain)* _____

If Yes, what is the average intake per day / week? _____

Has the Client ever been in trouble with the law? *Yes* *No* *(Explain)* _____

Are the Client's sleep patterns frequently altered? *Yes* *No* *(Explain)* _____

What are the Client's hobbies or interests? _____

Is Client outgoing (likes groups) or reserved (being alone)? *Outgoing* Reserved *Neither Extreme*

Is Client religious? *Yes* No What Faith? _____

What physical items does the Client value most? _____

Which family member is the Client closest to? _____

Where was the Client born and raised? _____

Is the Client afraid of: *dogs?* the dark? *noises?* *horses?* *people?* *- other -*

If other, please describe: _____

What action does the Client take when hurt? *cry* shout *remain silent* *hide* *- other -*

If other, please describe: _____

Would the Client talk to strangers? *Yes* No Would the Client approach strangers? *Yes* *No*

Does the Client have access to a vehicle? *Yes* No *(Describe)* _____

Could the Client be considered DANGEROUS to themselves or to others? *Yes* No

If yes, please describe: _____

If the Client is anxious or agitated what is the best way to calm them? _____

_____

Please list any other information that you feel needs to be shared concerning the Client? _____

_____

_____

- <u>To be completed by a Project Lifesaver Representative</u> -

Initial battery install date: _____ Transmitter Serial # _____

Client Representative: _____ Department: _____

New Client items completed:

☐ Personal Data Questionnaire ☐ Client Photograph ☐ Authorization to Release Information

☐ Agreement Summary ☐ Daily Test Log ☐ Caregiver Instructions ☐ Caregiver Instructions (Cards)