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: ______________________

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)