

Today's Date: _____

Part I: Information about the Caregiver

Caregiver's Name _____

Address _____

City _____ State _____ Zip _____ Phone _____

Parish: _____ Gender: Male Female

Caregiver EMAIL: _____

Caregiver's Marital Status: Single Married/Domestic Partner Widowed Other _____

Caregiver's Date of Birth: _____

Caregiver's Race:

- White Asian (race: _____)
African-American Pacific Islander (race: _____)
American Indian or Alaska Native
(principal tribe _____)

Caregiver's Fluent languages:

- English Spanish French Other: _____

Caregiver's Employment status:

- Works full-time Homemaker
Works part-time Unemployed
Retired; works part-time Other _____
Retired

What is the highest grade in school that the caregiver completed?

- 8th grade or less Associate Degree
Attended high school Bachelor's Degree
High school graduate (diploma or GED) Graduate degree or higher
Some college or post high school training

Caregiver's relationship to client/elder

- no caregiver identified spouse/domestic partner child/child-in-law sibling
other relative friend/neighbor professional care manager other: _____

Part II. Information about Client/Care Receiver

Client Name _____ Social Security No. _____

Address _____

City _____ State _____ Zip _____ Phone _____

Parish: _____ Gender: Male Female

Client Marital Status: Single Married/Domestic Partner Widowed Other _____

Date of Marriage: _____ Client/Elder's Date of Birth: _____

Client Height _____ Client Weight _____ Color of Eyes _____ Color of Hair _____

Client is Right-Handed Left-Handed Is Client a Veteran/Spouse of Veteran Y N

Physician Name: _____ Physician Phone: _____

Client's Race:

- White
- Black, African-American or Negro
- American Indian or Alaska Native
(principal tribe _____)

- Asian (race: _____)
- Pacific Islander (race: _____)

Client's Fluent languages:

- English
- Spanish
- French
- Other, list: _____

Physician's diagnosis (select one)

- Dementia
- Alzheimer Disease
- Pick's Disease
- Mild Cognitive Impairment
- Lewy Body Dementia
- Has not been diagnosed; Alzheimer's or other dementia is suspected
- Vascular
- Frontal Temporal Lobe Dementia
- Parkinson's
- Other related disorder,
explain _____

Approximate year of diagnosis: _____

Approximate date caregiver first noticed client/elder having memory problems: _____

Which stage did the physician say the client is in or do you think he/she is in:

Stage I: Mild

- Repeating themselves
- Getting lost in familiar places
- Losing interest in hobbies
- Forgetting common items
- Losing things more often
- Personality change

Stage II: Moderate

- Confused about recent events
- Not recognizing self in mirror
- Not recognizing family
- Unable to care for self
- Anxiety and/or depression

Stage III: Severe

- Inability to understand words
- Difficulty with simple tasks
- Arguing frequently
- Believing things are real that are not
- Repetitive actions or speech

Where does the client reside?

Lives alone in house or an apartment.

How many people including client/elder live in house/apartment? _____

Lives in house or apartment with others.

How many people including client/elder live in house/apartment? _____

Lives in a group environment with assistance (not a nursing home)

Lives in nursing home

Other _____

Does the client live with the primary caregiver? Yes No

Geographic location of client's residence :

rural or farm community (fewer than 2,500)

small city or town that is not suburb of a larger city (2,500 – 50,000)

medium city or suburb of a medium city (50,000 – 100,000)

large city or suburb of a large city (100,000 plus)

Indian reservation

Other: _____

PART III. Respite Center Enrollment.

Who referred you to the Alzheimer's Services Respite Center? _____

How much help, if any, does the client need with each of these activities?

	Needs no help/supervision	Needs some help/occasional supervision	Needs a lot of help/constant supervision	Can't do it at all
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in and out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting around inside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing heavy housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing light housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cooking/preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buying/getting food/clothes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting around outside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going places outside of walking distance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In a typical week, how many hours total did the caregiver help client with:

	hours per week
Eating, bathing, dressing or helping with toilet functions	_____
Meal preparation, laundry or light housework	_____
Providing transportation to appointments and/or shopping	_____
Legal matters, banking or money matters	_____

Which of the following services are the client and/or family currently using? (Check ALL services that are used by either the client/elder OR the caregiver)

- | | |
|---|---|
| <input type="checkbox"/> Companion or friendly visitor | <input type="checkbox"/> Transportation services |
| <input type="checkbox"/> Supervision | <input type="checkbox"/> Case management |
| <input type="checkbox"/> Homemaker services | <input type="checkbox"/> Support groups |
| <input type="checkbox"/> Chore services | <input type="checkbox"/> Caregiver training program |
| <input type="checkbox"/> Personal care services | <input type="checkbox"/> Psychological counseling |
| <input type="checkbox"/> Home health services | <input type="checkbox"/> Group meals/home delivered meals |
| <input type="checkbox"/> Adult daycare center/adult day health | <input type="checkbox"/> Other service: _____ |
| <input type="checkbox"/> Respite in a nursing home, adult foster home, or someone else's home | |

CONTINUE TO NEXT PAGE

Client Behavioral Information

For the following questions, check yes or no. Briefly explain or expand upon answers, as needed, in the space provided.

Is the client manageable for you at home at this time? Yes No

At home, does the client/elder have problems with:

a. sleep patterns: Yes No

b. eating habits: Yes No

c. mobility: Yes No

d. wandering: Yes No

e. incontinence: Yes No

f. level of anxiety: Yes No

g. level of cooperation: Yes No

h. level of contentment: Yes No

i. expressions of happiness: Yes No

j. other (e.g., change in medication): Yes No

Using the following scale, please rate the client's present day level of loneliness, helplessness, and boredom by circling the number of the best description for each.

	<u>None of the time</u>	<u>Some of the time</u>	<u>All of the time</u>
Loneliness	1	2	3
Helplessness	1	2	3
Boredom	1	2	3

Client Health and Demographic Information

Number and type of chronic diseases or physical impairments he/she has (check all that apply):

- None
- diabetes
- heart disease
- arthritis
- hypertension
- other _____

Number of visits by the doctor he/she has had in the past 12 months:

- none
- 1 to 3
- 4 to 6
- over 6

Number of hospital stays he/she has had in the past 12 months:

- none
- 1 to 3
- 4 to 6
- over 6

Number of physician prescribed medications he/she is currently taking:

- 1 to 4
- 5 to 8
- over 9

Does the client use any of the following appliances or aids? (check all that apply)

- Wheelchair
- Cane
- Walker
- Hearing Aid (right left)
- Eyeglasses
- Dentures (upper lower)

Does the client have difficulty with food, eating or swallowing?

- No
- Yes Please describe: _____

Does the client follow a special diet?

- No
- Yes Please describe: _____

Does the client have any allergies? (Includes food, drugs and environment)

- Drugs: _____
- Pollen
- Eggs
- Sulfa
- Dairy Products
- Insect Bites
- Other: _____

Future Directions

What other information would be helpful to you?

Please rate your interest in attending an educational workshop on each the following topics:

	<u>No Interest</u>	<u>A little</u>	<u>A great deal</u>
Incontinence care	1	2	3
Adaptive equipment (clothing, special utensils, etc)	1	2	3
Nutrition and dietary concerns	1	2	3
Managing problem behavior	1	2	3
Other _____	1	2	3