

Client Number: _____ Frequency: _____ ID Number or Code _____



Project Lifesaver of Clinton County
201 West Washington Street
Frankfort, Indiana 46041
Phone: 765-654-4277 x201 Fax: 765-654-6756

Client Personal Data Questionnaire

This form is designed for Custodial Care Givers to provide, in advance, certain information that will be useful to Search Teams, should the need arise. Providing the information in advance of the need will allow Search Management Personnel the necessary information to establish a more effective search response. **Return completed applications to Colleen Moore at the Frankfort Police Department.**

To be filled out by Project Lifesaver

Date Transmitter Placed: _____
Servicer filling out this form: _____
PL Servicer that places transmitter on: _____

Caregivers Personal Data

Facility/Organization/Caregiver: _____ Phone: _____
Address: _____
Relationship to Client: _____

Clients Personal Data

Full Name: _____
Birthday: _____ Sex: Male/Female Race: _____
Nickname(s): _____
Most recent address: _____
Most recent place of work: _____
Most recent occupation: _____
Name of Spouse: _____ Living/deceased (circle)

Family/Friend Information

Other persons the resident might contact (family, friends, etc.)

Name: _____ Phone: _____
Address: _____
Relationship to client: _____

Name: _____ Phone: _____
Address: _____
Relationship to client: _____

Responsible Party Paying for client: _____

Diagnosis: _____

Physical Description

Height ____ft. ____in. Weight _____lbs. Build _____ Complexion _____

Hair color _____ Hair Style _____ Eye Color _____

Beard: Yes No Mustache: Yes No Balding: Yes No False Teeth: Yes No

Shape of facial features: Round/Square/Oval/Other _____

Distinguishing marks, scars, tattoos, etc. _____

General Appearance _____

Languages other than English understood? _____

Speak? Yes No Read? Yes No Write? Yes No

Wear glasses? Yes No Contacts? Yes No Sunglasses Yes No

If yes to any of the above what style: _____

Degree of vision without eyewear? None Poor Fair (circle one)

Personal Data Questionnaire

Wear a hearing aid? Yes No What style? _____

If yes, what type of hearing without Aid? None/Poor/Fair (circle one)

Health/Psychological Condition

Any known physical handicaps? _____

Any known medical problems? _____

Medications taken regularly? _____

List any medication using correct name of drug and dosage being taken: _____

Consequences of NOT taking medications? _____

Attending Physician _____ Phone No. _____

Any Psychological Problems? Yes/No Nature _____

If Alzheimer's disease has been diagnosed, Answer the following:

1. Remains oriented to Time and Person? Yes No
Explain _____
2. Recognizes familiar persons and faces? Yes No
Explain _____
3. Able to travel to familiar locations? Yes No
Explain _____
4. Has decreased knowledge of current events or tend to re-live events in his/her life? Yes No
Explain _____
5. Sometimes clothe himself/herself improperly? Yes No
Example: Putting shoes on the wrong feet, adding underwear over clothing?
Explain if necessary _____
6. Remembers his/her own name and the names of spouse and or children? Yes No
Explain _____
7. Sleep patterns frequent or Sporadic?
Explain _____
8. Suffer from frequent personality and emotional changes? Yes No
Explain _____
9. Suffers from delusions (See Imaginary Visitors, Talk to his/her own reflection in the mirror, Imagine that their spouse is an imposter, etc?) Yes No
Explain _____
10. Communication ability? None Poor Fair Good Excellent

Personal Articles Normally Carried by the Resident:

Tobacco Products: Yes No Type _____ Brand _____

Candy/Gum: Yes No Brand _____

Matches: Yes No Lighter: Yes No Type _____

Food Items: _____

Facial tissue or other pocket/purse items: _____

Approximate Cash on Hand? \$ _____

Where Normally Carried _____

Handbag, Purse or Wallet:

Description _____ Type _____ Color _____

Jewelry (Please describe) _____

Watch? _____ Type _____ Color _____ Description _____

Equipment

Cane or /Walker _____ Hunting/Fishing, Etc. _____ (circle one or describe)

Other: _____

Experience

Ever go out alone? Yes No Where _____
Familiar with area? Yes No How recently _____ Days/Months/Years
If not local, what other areas are known to Resident? _____

Taken outdoor classes? Yes No Where? _____ When? _____
Taken first-aid training? Yes No Where? _____ When? _____
Involved in Scouting? Yes No Explain _____
Military Experience? Yes No Where? _____ When? _____
Outdoor Experience? Yes No _____
Camping Experience? Yes No _____ Day or Night _____
Ever been lost before? Yes No Where? _____
When _____ Time of Day _____
Location found _____
Actions taken _____

General Athletic Interest/Abilities _____

Personality Habits

Smoke? Yes No How often _____ what _____ Brand _____
Drink Alcohol? Yes No What Type? _____ Brand _____
Use Illicit Drugs? Yes No How often _____ Type _____
Evidence of Leadership Yes No Explain _____
Any trouble with the law? Yes No Explain _____
Religious? Yes No What faith _____
Received mail recently? Yes No From Whom _____
Afraid of Dogs? Yes No The dark? Yes No Noises? Yes No
Horses? Yes No People? Yes No Other (explain) _____
Talks to strangers? Yes No
Dangerous to self/others Yes No

Outgoing or Quiet _____ Likes Groups or being alone? _____

What does Resident value most? _____

Which family member is resident closest to? _____ Relationship _____

Where was Resident born and raised? _____

Reactions to hurt or pain? (Cry, shout, etc.?) _____