



# PROJECT LIFESAVER®

## Client Profile

### Personal Data Questionnaire



#### CLIENT INFORMATION

NAME:		SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
ADDRESS:			
CITY AND ZIP CODE:		NICKNAME (S)	
PHONE:	DOB:	NAME OF SPOUSE:	
DIAGNOSIS:			

#### CAREGIVER – 1 INFORMATION

NAME	
ADDRESS:	
EMAIL ADDRESS:	PHONE:
RELATIONSHIP TO CLIENT:	

#### CAREGIVER – 2 INFORMATION

NAME	
ADDRESS:	
EMAIL ADDRESS:	PHONE:
RELATIONSHIP TO CLIENT:	
OTHER PERSONS CLIENT MIGHT CONTACT:	

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### PHYSICAL DESCRIPTION

HEIGHT:	WEIGHT:	BUILD:
HAIR COLOR:	HAIR STYLE:	EYE COLOR:
BRIEFLY DESCRIBE ANY DISTIGUISHING SCARS, MARKS OR TATTOOS:		
GENERAL APPEARANCE:		
IF CLIENT DOES NOT UNDERSTAND ENGLISH, WHAT LANGUAGE IS UNDERSTOOD?		
DOES CLIENT USE GLASSES: <input type="checkbox"/> YES <input type="checkbox"/> NO	DOES CLENT WEAR HEARING AID(S)? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CLIENT USE: <input type="checkbox"/> CANE <input type="checkbox"/> WALKER	DOES CLIENT GO OUT ALONE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ADDITIONAL DETAILS OR EXPLANATIONS:		

### HEALTH CONDITIONS

LIST ANY KNOWN PHYSICAL HANDICAPTS:	
LIST ANY KNOWN MEDICAL CONDITIONS:	
MEDICATION TAKEN REGULARLY	DOSAGE OF MEDICATION TAKEN REGULARLY
ATTENDING PHYSICIAN	PHYSICIAN PHONE NUMBER:

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### EXPERIENCE

HAS CLIENT EVER WANDERED OFF? <input type="checkbox"/> YES <input type="checkbox"/> NO
WHEN?
WHERE:
LOCATION:

### HABITS

INTERESTS:
<input type="checkbox"/> OUTGOING <input type="checkbox"/> QUIET    LIKES: <input type="checkbox"/> GROUPS <input type="checkbox"/> WOULD RATHER BE ALONE
WHICH FAMILY MEMBER IS CLIENT CLOSEST TO?
CLIENT IS AFRAID OF:    DOGS <input type="checkbox"/> YES <input type="checkbox"/> NO    THE DARK <input type="checkbox"/> YES <input type="checkbox"/> NO    NOISES: <input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER (EXPLAIN)?
WHAT ACTIONS DOES CLIENT TAKE WHEN HURT OR FRIGHTENED? (CRY, SHOUT, ETC).
WILL CLIENT TALK TO STRANGERS: <input type="checkbox"/> YES <input type="checkbox"/> NO
IS CLIENT DANGEROUS TO HIMSELF/HERSELF /OTHERS: <input type="checkbox"/> YES <input type="checkbox"/> NO

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### PERSONAL ARTICLES NORMALLY CARRIED BY CLIENT

TABACCO PRODUCTS: <input type="checkbox"/> YES <input type="checkbox"/> NO		CANDY/GUM: <input type="checkbox"/> YES <input type="checkbox"/> NO	
MATCHES: <input type="checkbox"/> YES <input type="checkbox"/> NO		LIGHTER: <input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CLIENT CARRY CASH? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHERE IS CASH CARRIED?	
FOOD ITEMS:			

### IF ALZHEIMER'S OR DEMENTIA HAS BEEN DIAGNOSED ANSWER THE FOLLOWING:

DOES CLIENT REMAIN ORIENTED TO TIME AND PERSON?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DOES CLIENT RECOGNIZE FAMILIAR PERSONS AND FACES	<input type="checkbox"/> YES <input type="checkbox"/> NO
CAN THE CLIENT TRAVEL TO FAMILIAR LOCATIONS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DOES THE CLIENT SOMETIMES CLOTHE HIMSELF/HERSELF IMPROPERLY? (SHOES ON WRONG FOOT, UNDERWEAR OVER CLOTHING, ETC.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
DOES CLIENT REMEMBER OWN NAME AND THE NAMES OF SPOUSE AND/OR CHILDREN?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HOW WELL DOES CLIENT COMMUNICATE VERBALLY? <input type="checkbox"/> NONE <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> EXCELLENT	
ARE THERE ANY OTHER DEVICES CURRENTLY BEING USED TO TRACK THIS CLIENT? (I.E., FIND MY IPHONE, GPS DEVICES, ANGELSENSE, ETC.) IF YES, LIST DEVICES BELOW.	<input type="checkbox"/> YES <input type="checkbox"/> NO

#### Lincoln Police Department

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