

PROJECT LIFESAVER CLIENT PROFILE

Personal Data Questionnaire

This form is designed for 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 to have the necessary information to establish a more effective search response.

Client: _____

Address: _____

City: _____ Zip: _____

Phone: _____

Date of Birth: _____ Sex: Male Female Race: _____

Nickname(s): _____

Name of Spouse: _____

Diagnosis: _____

Caregiver(s)

Name: _____ Phone: _____

Address: _____

Relationship to Client: _____

Name: _____ Phone: _____

Address: _____

Relationship to Client: _____

Other persons the client might contact: _____

Physical Description

Height: _____ ft _____ in. Weight: _____ Build: _____

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

Complexion: _____

Distinguishing marks, scars, tattoos. Describe: _____

General Appearance: _____

If client does not understand English, what language is understood? _____

Does client wear glasses? Yes No Does client wear hearing aid(s)? Yes No

Does client use: Cane Walker Does client go out alone? Yes No Explain:

Health Condition

Any known physical handicaps? _____

Any known medical problems? _____

List medications taken regularly and dosage: _____

Attending Physician: _____ Phone: _____

Experience

Has client ever wandered off? Yes No When? _____

Where? _____

Located by searchers or returned home on own? _____

Habits

Interests: _____

Outgoing Quiet Likes groups or would rather be alone: _____

Which family member is client closest to? _____

Client is afraid of:

Dogs? Yes No The dark? Yes No

Noises? Yes No People? Yes No

Other (explain)? _____

What actions does client take when hurt or frightened? (cry, shout, etc.) _____

Will client talk to strangers? Yes No

Is client dangerous to himself/herself or others? Yes No

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

Does client remain oriented to time and person? Yes No

Does client recognize familiar persons and faces? Yes No

Can the client travel to familiar locations? Yes No

Does the client sometimes clothe himself/herself improperly? Yes No (shoes on wrong foot, underwear over clothing, etc.)

Does client remember own name and the names of spouse and/or children? Yes No

How well does the client communicate verbally? None Poor Fair Good Excellent

Personal Articles Normally Carried by Client

Tobacco products: Yes No

Candy / Gum: Yes No

Matches: Yes No Lighter: Yes No

Food items: _____

Cash? Amount: _____ Where carried? _____

ID Bracelet? Yes No