Care Management Clinic Pre-Assessment Questionnaire

Unless otherwise noted, please complete the Questionnaire for the Older Adult for whom the Clinic is being referred.

****Please be sure to email or fax the completed Questionnaire no later than 5:00 p.m. on Wednesday, September 15. Email: Clinics@SageEldercare.com; Fax: 408-907-9711.****

Name____

Your Name(s)____________________________ Relationship to Older Adult___________________

Address____

City____

Telephone____

Date of Birth ____________________ Age___________ Sex F__ M__

Chief Concern / Presenting Issue (Why did you register for the Care Management Clinic?):

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Marital Status: Married__ Widowed__ Single__ Separated__ Divorced__

Does he/she have children? Yes__ No__ If so, how many?______________

Is he/she a Veteran? Yes__ No__ If yes, which branch? _________________

Did/does he/she have a service connected injury? Yes__ No__

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What type of work did he/she do for most of his/her career? ________________________________

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Ethnic Origin: African American __ Hispanic/Latino __ Asian/Pacific Islander__
Native American __ Caucasian/White __ Other__________________

Has he/she completed a Power of Attorney for Healthcare? Yes__ No__ Not sure__

Has he/she completed a Power of Attorney for Financial Affairs? Yes__ No__ Not sure__

Has he/she completed a separate "Do Not Resuscitate" form? Yes__ No__ Not sure__

SOCIALIZATION

Approximately, how many people does he/she see on a regular basis? ________________________

Has he/she experienced any major changes in the last 6 months?____________________________
____
____

What is his/her religious affiliation? ____
Does he/she actively participate? Yes__ No __

Is he/she active in any groups/clubs/organizations? Please list: ____________________________
____

Does he/she attend any organized groups such as Adult Day Health, support groups etc.?
Yes __ No __
If so, which one(s)?____

Does he/she currently receive any outside services or support? Yes___ No___
If so, what type of support (for example: visiting nurse, physical therapy, psychotherapy, meal delivery, volunteer, etc.) and how often? ____
____
____

Present Hobbies:____
Former Hobbies: ____

Is he/she satisfied with his/her level of social activities? Satisfied __ Would like to do more __

Has he/she had changes in any of the following in the last 6 months?
Sleeping __ Weight loss __ Concentration __Energy Level __ Interest in activities __
If you checked any of the above, please provide additional details: __________________________
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LIVING SITUATION

Private residence and # of levels: ____
Apartment/Condo: ____
Live with relatives; Who?____
Independent senior housing name:____
Assisted Living or Board & Care name:_______________________________________
Skilled Facility/nursing home name:____
How long has he/she lived at his/her current residence? ______________________

Who, if anyone, lives with him/her: No one __Spouse __ Paid Employee __ Relative __
Is he/she satisfied with his/her living arrangement? Yes __ No __
Has he/she had his/her home safety fitted (for example, grab bars): Yes __ No __
Does he/she have a Lifeline emergency button? Yes __ No __

HEALTH

How would you describe his/her health status? Excellent __ Good __ Fair __ Poor __
Have you noticed any changes in his/her memory? Yes__ No__
If so, please provide examples: ____
____
____

Has his/her weight significantly changed in the last year? Yes__ No __
Does he/she receive help with remembering medications? Yes __ No __
Does he/she eat fewer than 3 meals per day? Yes __ No __
How often does he/she bathe per week? 1x __ 2x __ 3x or more__
How much alcohol does he/she drink on a daily basis? ___________________________
Is he/she hard of hearing? Yes __ No __ Does he/she you use a hearing aid? Yes __ No __
Is he/she visually impaired? Yes__ No___
Has he/she fallen in the past 6 months? Yes __ No __ If so, how often?_______________
Do you think that he/she is depressed? Yes __ No __
Has he/she ever visited a mental health professional (psychiatrist, psychologist, etc.)? Yes __ No __

Continence (Bladder): No problem ___ Accidents ___ No control___
Continence (Bowel): No problem ___ Accidents ___ No control____

Has he/she stayed in a hospital or nursing home in the last 2 years? Yes __ No __
If so, why?____

Please list any major medical problems:_______________________________________

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Does he/she use any assistive devices? Cane __ Walker __ Wheelchair __ Other _______________
Does he/she drive? Yes __ No __
Has he/she had driving accidents/citations? Yes __ No __
Does he/she use alternative transportation? Yes __ No __
If so, what type?____

Does he/she currently have paid help in the home? Yes__ No__
If so, how often? ____
Does the help come from an agency? Yes __ No __
If so, which agency? ____

ACTIVITIES OF DAILY LIVING QUESTIONNAIRE

Please answer the following questions about his/her ability to perform these tasks that are a necessary part of daily livfe. For each activity, please indicate what he/she can perform TODAY.

Able to bathe:	Independent____	Needs some help____	Dependent____
Able to dress/undress:	Independent____	Needs some help____	Dependent____
Able to walk:	Independent____	Needs some help____	Dependent____
Able to feed self:	Independent____	Needs some help____	Dependent____
Able to get in/out of bed:	Independent____	Needs some help____	Dependent____
Able to toilet:	Independent____	Needs some help____	Dependent____
Able to use telephone:	Independent____	Needs some help____	Dependent____
Able to run errands/shop:	Independent____	Needs some help____	Dependent____
Able to do housework:	Independent____	Needs some help____	Dependent____
Able to prepare meals:	Independent____	Needs some help____	Dependent____
Able to handle money/bills:	Independent____	Needs some help____	Dependent____
Able to manage medications:	Independent____	Needs some help____	Dependent____

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Please list any other specific concerns that you would like to the Care Manager to address:

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Thank you for taking the time to complete this Pre-Assessment Questionnaire.

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