INDIANA COUNTY DISTRICT ATTORNEYS OFFICE

825 Philadelphia Street * Indiana, PA 15701

Project Lifesaver International
Client Personal Data Questionnaire

Client Number: _____ Frequency: _____ ID Number/Code: _____

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.

Client: _____

Address: _____

City/State: _____ Zip: _____

Phone: _____

Date Transmitter Placed: _____

Caregiver: _____ Phone: _____

Address: _____

Servicer filling out this form: _____

Transmitter placed on: _____

Resident's Personal Data

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: _____

Diagnosis: _____

_____

_____

_____

Physical Description

Height: _____ Weight: _____ Build: _____

Complexion: _____ Hair Color: _____

Eye Color: _____ Hair Style: _____

Beard Mustache Balding False Teeth

Wear Glasses Contacts Sunglasses

Read Write Speak Hearing Aid

Shape of facial features: Round Square Oval Other

Distinguishing Marks: Tattoo Scar Marks Birthmarks

Other languages other than English understood? _____

Health/Psychological Condition

Any known physical handicaps: _____

Any known medical problems: _____

Medications taken regularly: _____

Medications: List correct name of drug and dosage being taken:

_____

_____

_____

Consequences if NOT taking medications? _____

_____

Attending Physician: _____ Phone: _____

Any Psychological problems/nature of problem: _____

_____

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

1. Remains oriented to time and place? 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 self improperly? Yes No (i.e. putting shoes on wrong feet, underwear over clothing)

   Explain: _____

6. Remembers his/her own name and names of spouses/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 (sees imaginary visitors, talks to self, imagine that spouse is imposter, etc.?) Yes No

   Explain: _____

10. Communication ability? None Poor Fair Good Excellent

Personal articles normally carried by client:

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/Wallet: Description: _____

Jewelry: Description: _____

Equipment Use

Cane Walker Wheelchair Hunting Fishing

EXPERIENCE

Ever go out alone? Yes No Where: _____

Familiar with area? Yes No How recent: _____

If not local, what other areas are known to client: _____

Taken outdoor classes? Yes No Explain: _____

Taken First-Aid? Yes No

Involved in Scouting? Yes No Explain: _____

Military Experience? Yes No Explain: _____

Outdoor Experience? Yes No Explain: _____

Ever been lost before? Yes No Explain: _____

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: _____

Illicit Drugs? Yes No How Often: _____ Type: _____

Religious? Yes No What Faith: _____

Afraid of Dogs? Yes No Cats? Yes No Horses? Yes No

Afraid of Dark? Yes No The Dark? Yes No Noises? Yes No

Talk to strangers? Yes No

Danger to self or others? Yes No Explain: _____

Trouble with the law? Yes No Explain: _____

Outgoing OR Quiet? Likes being Alone or in Groups?

What does client value most? _____

Which family member is client close with? _____

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