



Monroe County Project Lifesaver

Personal Data Questionnaire

This form is designed to provide Client information that will be useful to Project Lifesaver team members and search teams should the need arise. Providing this information, in advance, will assist team members in providing a more effective response, should the Client go missing?

Please complete this form to the best of your ability. If additional space is needed, feel free to write in the margins or add additional pages as necessary.

Client Information:

Client Name: _____
First Middle Last Nickname

Primary Diagnosis: _____ Date of Birth: _____

Gender: *Male Female* Ethnicity: _____ Skin Complexion: *Light Medium Dark*
(Circle) *(Circle One)*

Mental Capacity (Age): _____ Height: _____ Weight: _____

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

Balding? *Yes No* Sideburns? *Yes No* Facial Hair? *Yes No* _____
(If Yes, then describe)

_____ Build: *Thin Muscular Heavy* False Teeth? *Yes No*
(Circle One)

Distinguishing Features: _____
(Marks, Scars, Tattoos, Etc.)

General Appearance: *(Anything additional - not covered above)* _____

Client's Residence:

Home Address: _____
Street *Town*

Zip Code: _____ County: _____ Township: _____

Home Phone: _____ Subdivision Name: _____

Fenced yard? *Yes No* Nearby pool or retention pond? *Yes No* _____
(If Yes, Where?)

Other pertinent info about the home: _____

Caregiver Information:

Caregiver 1

Name: _____ Relation to Client: _____

Address: _____
Street *Town* *Zip*

Primary Phone: _____ Alternate Phone: _____

Email address: _____

Caregiver 2

Name: _____ Relation to Client: _____

Address: _____
Street *Town* *Zip*

Primary Phone: _____ Alternate Phone: _____

Email address: _____

Caregiver 3 (if applicable)

Name: _____ Relation to Client: _____

Address: _____
Street *Town* *Zip*

Primary Phone: _____ Alternate Phone: _____

Email address: _____

Client/Caregiver Preliminary Questions:

Is the Client continuously supervised? (A caretaker is present 24 hours a day, 7 days a week)	<i>Circle One</i> Yes No
Will the Client be willing to wear a wrist transmitter at all times?	Yes No
- If No, will the Client be willing to wear an ankle transmitter at all times?	Yes No
Are you, as the caregiver, willing to abide by the requirements of the program?	Yes No
Do you agree to explain the program to all 'temporary' caregivers and confirm that they understand and are willing to abide by the program requirements?	Yes No

Client Background & Routine:

Does the Client attend school or other supervised care program outside the home? Yes No

If yes, please complete the following:

School / Program Name: _____							
Facility Address: _____							
Phone: _____				How long have they attended? _____			
General	Sun.	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.
Schedule: _____							
Teachers Name: _____				Email: _____			
How is client transported: _____							

Does the Client have a history of aggressive or violent behavior? Yes No

Does the Client presently operate a motor vehicle? Yes No

Most recent place of employment: *(if applicable)* _____

Most recent occupation: *(if applicable)* _____

Communication:

Is the Client able to communicate? Yes No Is the Client able to read? Yes No

Client can: *Speak Write Sign Mute Deaf Other:* _____
(Circle all that apply) *(Explain)*

Does the Client speak English? Yes No If No, what language is understood? _____

Does the Client regularly wear Glasses? *Yes No* Contacts? *Yes No* Sunglasses? *Yes No*

If Yes to any of the above, please describe: _____

What degree of vision does the Client have without eyewear? *Good Fair Poor None*
(Circle One)

Does the Client wear a hearing aid? *Yes No* If so, what style? _____

What degree of hearing does the Client have without an Aid? *Good Fair Poor None*
(Circle One)

Does the Client wear a watch or any other jewelry on the wrist? *Yes No* Necklace? *Yes No*

Client Medical History:

Please list any major medical conditions:

Medical Condition 1: _____

Description: _____

Medical Condition 2: _____

Description: _____

Medical Condition 3: _____

Description: _____

Medical Condition 4: _____

Description: _____

Medical Condition 5: _____

Description: _____

Medications: (Please list all Long-Term prescriptions)

Rx 1: _____ Dosage: _____

Condition that Rx 1 is prescribed? _____

Consequences of **NOT** taking Rx 1: _____

Rx 2: _____ Dosage: _____

Condition that Rx 2 is prescribed? _____

Consequences of **NOT** taking Rx 2: _____

Rx 3: _____ Dosage: _____

Condition that Rx 3 is prescribed? _____

Consequences of **NOT** taking Rx 3: _____

Physicians:

Physician 1: _____ Phone: _____

Physician Type: _____

Physician 2: _____ Phone: _____

Physician Type: _____

Physician 3: _____ Phone: _____

Physician Type: _____

Does the Client have mobility problems? *Yes No (If Yes, describe)* _____

Does the Client use mobility assistance? *Yes No (If Yes, describe)* _____

Does the Client carry any Identification? *Yes No (If Yes, where)* _____

Personal Items Normally Carried by the Client:

Candy or Gum? *Yes No (Type & Brand)* _____

Tobacco Products? *Yes No (Type & Brand)* _____

Matches or Lighters? *Yes No (Type & Brand)* _____

Food Items? *Yes No (Type & Brand)* _____

Handbag, Purse, or Wallet? *Yes No (Describe)* _____

Other Pocket or Purse items? _____

Does the Client Typically carry - *Cash? Checkbook? Credit Card?*
(Circle all that apply)

Any other items typically carried? _____

Client Experience:

Is the Client familiar with the area? *Yes No* Length of residence? _____

If not local, what other areas are known by the Client? _____

Has the Client . . .

- been involved with Scouting? *Yes No* Explain: _____

- had First Aid training? *Yes No* Explain: _____

- had outdoor survival training? *Yes No* Explain: _____

- ever been lost before? *Yes No* - When & Where: _____

Was the Client found or did they come back on their own? _____

Location found: _____ Other pertinent information: _____

Does the Client . . .

- have previous Military experience? *Yes No* Explain: _____

- have outdoor recreational experience? *Yes No* Explain: _____

- overnight camping experience? *Yes No* Explain: _____

- ever go out alone? *Yes No* Explain: _____

What preventative measures have been taken in the home to prevent the client from wandering? _____

Through experience, is there a “most effective” way to approach the Client? *Yes No*

If *Yes*, Please explain: _____

If Alzheimer’s disease or Dementia has been diagnosed, answer the following:

When was the Client diagnosed? _____ Name of Spouse? _____ Living / Deceased

What is the best way to communicate with the Client? _____

Does the Client remain oriented to Time and Person? *Yes No (Explain)* _____

Does the Client recognize familiar people? *Yes No (Explain)* _____

Can the Client travel to familiar locations? *Yes No (Explain)* _____

Does the Client have a decreased knowledge of current events or tend to re-live past events? *Yes No (Explain)* _____

Does the Client remember his/her own name and the names of spouse and/or children? *Yes No (Explain)* _____

Does the Client suffer from delusions (See imaginary visitors, claim that their spouse / family are imposters, etc)? *Yes No (Describe)* _____

If Autism or Down syndrome has been diagnosed, answer the following:

When was the Client diagnosed? _____

What is the best way to communicate with the Client? _____

Does the Client have unusual reactions to sensory environment (touch, sound, bright lights, odors, and / or animals)? *Yes No (Describe)* _____

Does the Client engage in self-stimulatory behavior? (hand-flapping, finger flicking, rocking, spinning, or or shaking parts of their body)? *Yes No (Describe)* _____

Is the Client attracted to water? *Yes No* Does the Client know how to swim? *Yes No*

Is the Client insensitive to pain? *Yes No* Does the Client react differently to foods? *Yes No*

What foods would they - react well to? _____ react negatively to? _____

Does the Client have trouble with direct eye contact? *Yes No*

Does the Client dart away from you unexpectedly (bolt and run)? *Yes No*

Family & Friend Information: *(Other people the Client may try to contact)*

Name: _____ Relation: _____

City: _____ State: _____

Name: _____ Relation: _____

City: _____ State: _____

Name: _____ Relation: _____

City: _____ State: _____

Name: _____ Relation: _____

City: _____ State: _____

Personality & Habits:

Does the Client . . .

- know/respond to his/her name? *Yes No (Explain)* _____

- Sometimes dress 'improperly'? *Yes No (Explain)* _____

- suffer from frequent personality and/or emotional changes? *Yes No (Describe)* _____

- wear a medical ID bracelet or other device to identify disability? *Yes No (Describe)* _____

- wear a "Safe Return" bracelet? *Yes No (Describe)* _____

- show evidence of Leadership? *Yes No (Describe)* _____

- have difficulty judging personal space? *Yes No (Describe)* _____

- swim or participate in water based activities? *Yes No (Explain)* _____

- drink Alcohol or use illicit drugs? *Yes No (Explain)* _____

 If Yes, what is the average intake per day / week? _____

Has the Client ever been in trouble with the law? *Yes No (Explain)* _____

Are the Client's sleep patterns frequently altered? *Yes No (Explain)* _____

What are the Client's hobbies or interests? _____

Is Client outgoing (likes groups) or reserved (being alone)? *Outgoing Reserved Neither Extreme*

Is Client religious? *Yes No* What Faith? _____

What physical items does the Client value most? _____

Which family member is the Client closest to? _____

Where was the Client born and raised? _____

Is the Client afraid of: *dogs?* *the dark?* *noises?* *horses?* *people?* - *other* -

If other, please describe: _____

What action does the Client take when hurt? *cry* *shout* *remain silent* *hide* - *other* -

If other, please describe: _____

Would the Client talk to strangers? *Yes* *No* Would the Client approach strangers? *Yes* *No*

Does the Client have access to a vehicle? *Yes* *No* (*Describe*) _____

Could the Client be considered DANGEROUS to themselves or to others? *Yes* *No*

If yes, please describe: _____

If the Client is anxious or agitated what is the best way to calm them? _____

Please list any other information that you feel needs to be shared concerning the Client? _____

- To be completed by a Project Lifesaver Representative -

Initial battery install date: _____ Transmitter Serial # _____

Transmitter Frequency _____

Client Representative: _____ Department: _____

New Client items completed:

Personal Data Questionnaire Client Photograph Authorization to Release Information

Agreement Summary Daily Test Log Caregiver Instructions Caregiver Instructions (Cards)