Caregiver Information

#### \*Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, St. Zip**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The best time to reach you:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*DOB**: \_\_\_\_\_\_\_\_\_\_\_ \***SS#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Is it ok to call you at work?** Yes No

**Veteran Status:** Yes No \***Age**: \_\_\_\_\_

**Sex**: Male Female \***Gender**: Man Woman No Resp./Other

**Which best represents how you think of yourself:**

Straight (not gay, lesbian or bisexual) Bisexual

Gay or lesbian Not listed above (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Race:**

Hispanic/Latino No Response Native Hawaiian or other Pacific Islander

Asian Reporting 2 or More Races Caucasian

African American Other American Indian/Alaskan Native

**\*Lives with:** Alone **Education Level: (# of years)**  \_\_\_\_

Group Sett. Spouse / Family \***Number of Care Receivers Assisting:** \_\_\_\_

Fam / Friend No Response \***Number of other Dependent Family Members:** \_\_\_\_

**\*Caregiver Employment:** Full-Time Part-Time Retired Leave of Absence Not Employed

**Has your employment status changed due to caregiving duties?**

Increased Hours Changed Jobs No Change Laid Off

Decreased Hours Leave of Absence Began Working Other

Early Retirement Family / Medical Leave Quit Job

**How would you rate your own health (caregiver health)?** Excellent Good Fair Poor

**What health conditions and concerns do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Living arrangement:**  \***Marital Status:**

Assisted Living Independent Senior Housing Married Widowed

Homeowner/co-owner Rents/lives with Family/Fiends Divorced No Response

Nursing Facility/Institution Other Single

No Response

**Relationship to Client:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Frequency of Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What type of care / assistance does the caregiver typically provide to the care receiver?**

Hygiene (bathing, grooming, etc.) Errands / Shopping Maintenance of Home / Yard

Dressing Managing Finances / Paying Bills Cleaning of Home

Meal Preparation / Eating Administration of Medication Laundry / Housekeeping

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Treatment / Managing Medical Condition Transportation

**Is respite care available to the caregiver as needed (for the care receiver)?** Yes No

**If yes, please describe:**

**What other sources of support in caregiving (to care receiver) are currently in place? Who provides this support and what is provided? (any paid, professional or informal care or support)**

Service Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Service Provider Contact Info (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_

Hygiene (bathing, grooming, etc.) Errands / Shopping Maintenance of Home / Yard

Dressing Managing Finances / Paying Bills Cleaning of Home

Meal Preparation / Eating Administration of Medication Laundry / Housekeeping

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Treatment / Managing Medical Condition Transportation

**Do you receive emotional support from your family, friends, neighbors, etc?** Yes No

**If yes, how would you rate this support (please describe)?**

**Are there cultural factors present (observed or mentioned)?** YesNo

**If yes, please describe the cultural factors and their effect on caregiving:**

**Do you receive satisfaction from caregiving?** YesNo

**Comments:**

**How do you cope / handle stress?**

**What do you do to take care of yourself?**

**\*Caregiver Stress Survey**

Check the following number depending on the level of stress

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Never  0 | Seldom  1 | Sometimes  2 | Often  3 | Usually  4 | Always  5 |
| I can’t get enough rest. |  |  |  |  |  |  |
| I don’t have enough time for myself. |  |  |  |  |  |  |
| I don’t have enough time to  be with other family members because of my care giving responsibilities. |  |  |  |  |  |  |
| I feel guilty about my situation. |  |  |  |  |  |  |
| I don’t see old friends and  get out much anymore. |  |  |  |  |  |  |
| I have conflicts with the  person in my care. |  |  |  |  |  |  |
| I have conflicts with other  family members. |  |  |  |  |  |  |
| I cry everyday. |  |  |  |  |  |  |
| I worry about having enough  money to make ends meet. |  |  |  |  |  |  |
| I don’t feel I have enough  knowledge or experience to  give care, as I would like. |  |  |  |  |  |  |
| My own health is not good. |  |  |  |  |  |  |
| Care giver responsibilities are  forcing me to be absent from  work and experience a loss of  productivity. |  |  |  |  |  |  |
| I feel like I am all alone in  this care giving process. |  |  |  |  |  |  |

**Caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Care Receiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_**

**Care Receiver Information**

#### \*Care Receiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, St. Zip**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**\*DOB**: \_\_\_\_\_\_\_\_\_\_\_ \***SS#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Is it ok to call you at work:** Yes No

**Veteran Status:** Yes No **Age**: \_\_\_\_\_ **Lives** **Alone**: Yes No

**Sex**: Male Female **Gender**: Man Woman Other\_\_\_\_\_\_

**Race:** African American Hispanic/Latino American Indian/Alaskan Native Caucasian Asian

Native Hawaiian/other Pacific Islander Reporting 2 or More Races Other No Response

**Do you receive significant or daily help from family, friends or neighbors?**  Yes No

**Do you currently receive any assistance from our Agency?** Yes No

**Health**

**How do you rate your health at the present time?**  Excellent Good Fair Poor

**What health conditions and concerns do you have:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you fallen in the past six months?**  Yes No **If Yes, how many times?** \_\_\_\_\_

**Have you been in the hospital in the past six months?**  Yes No

**If yes, what was the reason for your hospitalization?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any other concerns about your health and safety?** Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cognitive**

**\*Does the client exhibit memory loss, disorientation, and difficulty with problem solving, impaired judgment or other cognitive impairment?** Yes No No Response

**If yes**, **please explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*ADL Description & Assistance Level**

***Independent*** *- Help or oversight required fewer than 1-2 times in a week*

***Supervision -*** *Oversight, encouragement, cueing 3+ times or physical assistance 1-2 times in a week*

***Limited Assistance -*** *Help in maneuvering limbs 3+ times in a week or more help 1-2 times in a week*

***Extensive assistance -*** *Weight-bearing assistance 3+ times in a week, but not at all times*

***Total dependence -*** *Complete assistance at all times*

**Bathing Deficit ⬜**

⬜ Independent

⬜ Supervision

⬜ Limited Assistance

⬜ Extensive Assistance

⬜ Total Dependence

**Dressing Deficit ⬜**

⬜ Independent

⬜ Supervision

⬜ Limited Assistance

⬜ Extensive Assistance

⬜ Total Dependence

**Eating Deficit ⬜**

⬜ Independent

⬜ Supervision

⬜ Limited Assistance

⬜ Extensive Assistance

⬜ Total Dependence

**Locomotion Deficit ⬜**

⬜ Independent

⬜ Supervision

⬜ Limited Assistance

⬜ Extensive Assistance

⬜ Total Dependence

**Toileting Deficit ⬜**

⬜ Independent

⬜ Supervision

⬜ Limited Assistance

⬜ Extensive Assistance

⬜ Total Dependence

**Transfer Deficit ⬜**

⬜ Independent

⬜ Supervision

⬜ Limited Assistance

⬜ Extensive Assistance

⬜ Total Dependence

Total Deficits **\_\_\_\_**

Comments:

**\*Care Receiver Behavioral Symptoms**

**Symptom No Response Never Sometimes Often Usually**

Physical Abusive \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Resists Care \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Sleep Cycle issues \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Socially inappropriate \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Verbally Abusive \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Wandering \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Disruptive Behavior \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**Name of Care Receiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Completed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notes / Narratives:**

Office Use:

Care Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Status: Active\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Inactive: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_