Caregiver Information

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

**The best time to reach you:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is it ok to call you at work?** Yes No

**\*Education Level: (# of years)**  \_\_\_\_

\***Number of Care Receivers Assisting:** \_\_\_\_

\***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:**

 Assisted Living Independent Senior Housing

 Homeowner/co-owner Rents/lives with Family/Fiends

 Nursing Facility/Institution Other

 No Response

**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  | Seldom1 | Sometimes2 | Often3 | Usually4 | Always5 |
| I can’t get enough rest. |  |  |  |  |  |  |
| I don’t have enough time for myself. |  |  |  |  |  |  |
| I don’t have enough time tobe with other family members because of my care giving responsibilities. |  |  |  |  |  |  |
| I feel guilty about my situation. |  |  |  |  |  |  |
| I don’t see old friends andget out much anymore. |  |  |  |  |  |  |
| I have conflicts with theperson in my care. |  |  |  |  |  |  |
| I have conflicts with otherfamily members. |  |  |  |  |  |  |
| I cry everyday. |  |  |  |  |  |  |
| I worry about having enoughmoney to make ends meet. |  |  |  |  |  |  |
| I don’t feel I have enoughknowledge or experience to give care, as I would like. |  |  |  |  |  |  |
| My own health is not good. |  |  |  |  |  |  |
| Care giver responsibilities are forcing me to be absent fromwork and experience a loss ofproductivity. |  |  |  |  |  |  |
| I feel like I am all alone inthis care giving process. |  |  |  |  |  |  |

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

**Care Receiver Information**

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

**The best time to reach you:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is it ok to call you at work:** Yes No

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_