PRE-SCREENING QUESTIONNAIRE

CURRENT LIVING SITUATION

I currently live: ❑ In own home/apartment ❑ Senior community ❑ Other: _____
❑ Alone ❑ With spouse ❑ With other family member(s) ❑ With friend/significant other

Have you ever lived in another senior residence? ❍ No ❍ Yes specify: _____

ASSISTANCE NEEDED

Area of Assistance	No	Yes	Assistance/Information	Comments
1. Bathing			Type of bath preferred: _____ ❑ Preparation (set-up) ❑ Getting in and out of tub/shower ❑ Other: _____	
2. Ambulation			Aid used: ❑ Cane ❑ Walker ❑ Wheelchair ❑ Other: _____	
Prosthesis Used			Type of prosthesis: _____	
3. Waking Up/Getting Out of Bed			❑ Waking ❑ Getting out of bed ❑ Dressing/undressing ❑ Fasteners only ❑ Shoes/stockings only ❑ Complete assist ❑ Needs prompts ❑ Oral care ❑ Hair care	
Preparing for bed/ Getting into bed			❑ Sleeps in bed ❑ Sleeps sitting up ❑ Problems with sleep: _____	
4. Daytime Monitoring			Number of times OR frequency: _____ (i.e., every 2 hours)	
Nighttime Monitoring			Number of times OR frequency: _____	
5. Toileting			❑ Uses protective undergarments Type: _____ ❑ Needs help changing ❑ Reminders ❑ Assistance ❑ Transfer assistance	
6. Special Diet Needs			❑ Diabetic ❑ Low sodium ❑ Low fat ❑ Vegetarian ❑ Other: _____ ❑ Personal preference	
Do you know what foods you shouldn't eat?			❑ Religious preference ❑ Ordered by your physician	
7. Dining/Eating			❑ Swallowing or chewing problems ❑ Special utensils: _____ ❑ Assistance getting to/from dining room ❑ Other: _____	
8. Medications			❑ Reminder to take medication ❑ Assistance with taking medication Number of medications taken: _____	
Over-the-counter (OTC)				
Prescription meds				
Injections				
9. Personal Affairs			❑ Making appointments ❑ Appointment reminders ❑ Transportation to/from appointments ❑ Paying bills ❑ Assistance with shopping ❑ Assistance with telephone ❑ Other: _____	
10. Social/Activities			❑ Reminders about activities ❑ Assistance getting to activities ❑ Other: _____	
11. Housekeeping (other than cleaning provided weekly)			❑ Daily tidying ❑ Daily bed making ❑ Laundry ❑ Other: _____	

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

PHYSICAL/SOCIAL CONSIDERATIONS

1. List all current physical conditions we need to be aware of (i.e., heart disease, diabetes, cancer, arthritis, COPD, seizures, Parkinson's, past stroke):_____
2. Have you been diagnosed with any form of dementia (i.e., Alzheimer's)? ❍ No ❍ Yes Explain:
   _____
3. Are you currently under a physician's care for any of the conditions listed in #1? ❍ No ❍ Yes Explain:
   _____
4. Do you smoke/use tobacco products? ❍ No ❍ Yes How much/how often?
5. Do you drink alcoholic beverages? ❍ No ❍ Yes Frequency/amount:_____
6. Do you enjoy living with other people? ❍ No ❍ Yes Explain:_____
7. Do you get nervous around other people? ❍ No ❍ Yes Explain:_____
8. Are you shy with people you don't know? ❍ No ❍ Yes Explain:_____
9. Do you feel frightened when alone? ❍ No ❍ Yes Explain:_____
10. Do you feel down, depressed or hopeless? ❍ No ❍ Yes Explain:
11. Have you personally ever felt out of control? ❍ No ❍ Yes Explain:
12. Do you sometimes have trouble with forgetfulness? ❍ No ❍ Yes, what kinds of things do you forget?
    _____
13. Do you have Advance Directives (Living Will, Health Care Proxy, POLST/MOLST or POST/MOST)?
    ❍ No ❍ Yes Explain:_____
14. If No, would you like information about Advance Directives? ❍ No ❍ Yes
15. How would you like to receive information from this facility? (i.e., large print, regular print, audio, video, etc.)
    _____
16. How do you feel about moving into a facility? Explain:

ADDITIONAL INFORMATION

Use this section to identify any other special needs you have that have not been discussed on this questionnaire.

_____ _____

Person Completing Questionnaire/Title Date