Client Number:_____ **Client Startup Date:** _____

PROJECT LIFESAVER HENDRICKS COUNTY, INC.

Personal Data Questionnaire

This form is designed to provide information on the Client 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, please write in the margins and/or add additional pages as necessary.

Client Information:

Client Name: _____ _____
First *Middle* *Last* *Nickname(s)*

Gender: _____ Date of Birth: _____ Mental Capacity (Age): _____

Diagnosis: _____
(Please list all) _____
_____
_____

Height: _____ Weight: _____ Build: _____

Ethnicity: _____ Skin Complexion: _____

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

Does the Client Have…	Please Circle		**IF YES,** Please Describe…
Facial Hair?	*Yes*	*No*	
Sideburns?	*Yes*	*No*	
Bald Spots?	*Yes*	*No*	
False Teeth?	*Yes*	*No*	
Scars?	*Yes*	*No*	
Tattoos?	*Yes*	*No*	

Client Residence:

Home Address: _____

City: _____ Township: _____ Zip Code: _____

Subdivision Name (if applicable): _____

Does the Residence Have…	Please Circle		**IF YES,** Please Describe:
Fenced Yard?	*Yes*	*No*	_____
Nearby Pool?	*Yes*	*No*	_____
Nearby Retention Pond?	*Yes*	*No*	_____

Is the Client familiar with the area? _____ Length of residence: _____

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

_____

Primary Caregiver Information:

Caregiver #1

Name: _____ Relation to Client: _____

Address: _____

Primary Phone: _____ Alternative Phone: _____

Email Address: _____

Caregiver #2

Name: _____ Relation to Client: _____

Address: _____

Primary Phone: _____ Alternative Phone: _____

Email Address _____

Caregiver #3

Name: _____ Relation to Client: _____

Address: _____

Primary Phone: _____ Alternative Phone: _____

Email Address: _____

Preliminary Questions:

	Circle One	
Is the Client continuously supervised?	*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 Communication Details:

Please complete the following for any language that the Client knows

Language	Client Can… *(circle all that apply)*		
_____	*Speak*	*Read*	*Understand*
_____	*Speak*	*Read*	*Understand*
_____	*Speak*	*Read*	*Understand*
_____	*Speak*	*Read*	*Understand*

Other method(s) of communication: _____

Does the Client regularly wear…	Please Circle		**IF YES,** Please Describe:
Glasses?	*Yes*	*No*	_____
Contacts?	*Yes*	*No*	_____
Sunglasses?	*Yes*	*No*	_____
Hearing aids?	*Yes*	*No*	_____

What degree of vision does the Client have without eyewear? _____

What degree of hearing does the Client have without an aid? _____

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

IF YES, please explain: _____

Client Personality, Background, & Routine:

Please complete the following for any schools or other supervised care programs the Client attends outside of the home:

School/Program Name: _____

Facility Address: _____

Facility Phone: _____ How long have they attended? _____

General Schedule:

Sun	*Mon*	*Tues*	*Wed*	*Thu*	*Fri*	*Sat*

Name of Teacher/Coordinator: _____ Email: _____

How Client is transported to school/program: _____

School/Program Name: _____

Facility Address: _____

Facility Phone: _____ How long have they attended? _____

General Schedule:

Sun	*Mon*	*Tues*	*Wed*	*Thu*	*Fri*	*Sat*

Name of Teacher/Coordinator: _____ Email: _____

How Client is transported to school/program: _____

Has the Client ever been lost before? If so, please use the space below to describe the incident(s):
[ex: when and where they went missing, whether they returned on their own or were found, etc.]

_____

_____

_____

_____

_____

_____

Does the Client…	Please Circle		**IF YES,** Please Describe:
Have a history of aggressive/violent behavior?	*Yes*	*No*	
Have mobility issues?	*Yes*	*No*	
Use mobility assistance?	*Yes*	*No*	
Have access to a vehicle?	*Yes*	*No*	
Presently operate a vehicle?	*Yes*	*No*	
Know/Respond to their name?	*Yes*	*No*	
Sometimes dress "improperly"?	*Yes*	*No*	
Suffer from frequent personality shifts?	*Yes*	*No*	
Suffer from frequent emotional shifts?	*Yes*	*No*	
Have difficulty judging personal space?	*Yes*	*No*	
Have frequently changing sleep patterns?	*Yes*	*No*	
Ever pose a danger to themselves?	*Yes*	*No*	
Ever pose a danger to others?	*Yes*	*No*	
Know how to swim?	*Yes*	*No*	

Would the Client…	Please Circle		**IF YES,** Please Describe:
Be considered outgoing?	*Yes*	*No*	
Talk to strangers?	*Yes*	*No*	
Approach strangers?	*Yes*	*No*	
Be considered religious?	*Yes*	*No*	

Does the Client normally carry…	Please Circle		**IF YES,** Please Describe:
Candy or gum?	*Yes*	*No*	
Tobacco products?	*Yes*	*No*	
Matches or lighters?	*Yes*	*No*	
Food items?	*Yes*	*No*	
A handbag, purse, or wallet?	*Yes*	*No*	

Does the Client normally wear…	Please Circle		**IF YES,** Please Describe:
A watch?	*Yes*	*No*	
Jewelry?	*Yes*	*No*	
A medical ID bracelet?	*Yes*	*No*	
A "Safe Return" bracelet?	*Yes*	*No*	
A Life Alert?	*Yes*	*No*	

Has the Client been involved with…	Please Circle		**IF YES,** Please Describe:
Scouting?	*Yes*	*No*	
First aid training?	*Yes*	*No*	
Outdoor survival training?	*Yes*	*No*	

Does the Client…	Please Circle		**IF YES,** Please Describe:
Have military experience?	*Yes*	*No*	
Have outdoor recreational experience?	*Yes*	*No*	
Overnight camping experience?	*Yes*	*No*	
Have a job?	*Yes*	*No*	
Ever go out alone?	*Yes*	*No*	
Smoke?	*Yes*	*No*	
Drink alcohol?	*Yes*	*No*	
Use illicit drugs?	*Yes*	*No*	

What are the Client's hobbies/interests? _____

What physical items does the Client value most? _____

What family member is the Client closest to? _____

What is the Client afraid of? _____

What action(s) does the Client take when hurt? _____

Please describe any time the Client has been in trouble with the law:

_____

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

_____

_____

Please use this space to share any other information you feel needs to be shared concerning the Client:

_____

_____

_____

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: _____

Please list any long-term prescriptions:

Rx 1: _____ Dosage: _____

Condition that Rx 1 is prescribed for: _____

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

Rx 2: _____ Dosage: _____

Condition that Rx 2 is prescribed for: _____

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

Rx 3: _____ Dosage: _____

Condition that Rx 3 is prescribed for: _____

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

Rx 4: _____ Dosage: _____

Condition that Rx 4 is prescribed for: _____

Consequences of **NOT** taking Rx 4: _____

Please list the Client's physicians:

Physician 1: _____ Phone: _____

Physician Type: _____

Physician 2: _____ Phone: _____

Physician Type: _____

Physician 3: _____ Phone: _____

Physician Type: _____

Please complete the following if the Client has been diagnosed with Alzheimer's or Dementia

When was the Client diagnosed? _____

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

Does the Client…	Please Circle		Please Describe:
Remain oriented to time and place?	*Yes*	*No*	
Recognize familiar people?	*Yes*	*No*	
Travel to familiar locations?	*Yes*	*No*	
Relive personal events?	*Yes*	*No*	
Remember their name?	*Yes*	*No*	
Remember spouse's name?	*Yes*	*No*	
Remember children's names?	*Yes*	*No*	
Suffer from delusions?	*Yes*	*No*	

Please complete the following if the Client has been diagnosed with Autism or Down Syndrome

When was the Client diagnosed? _____

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

Is the Client…	Please Circle		Please Describe:
Sensitive to environmental changes?	*Yes*	*No*	
Attracted to water?	*Yes*	*No*	
Insensitive to pain?	*Yes*	*No*	

Does the Client…	Please Circle		Please Describe:
Engage in self-stimulatory behavior?	*Yes*	*No*	
React differently to specific foods?	*Yes*	*No*	
Have trouble with direct eye contact?	*Yes*	*No*	
Dart away from you unexpectedly?	*Yes*	*No*	