PROJECT LIFESAVER CLIENT PROFILE

Personal Data Questionnaire

This form is designed for Care Givers to provide, in advance, certain information that will be useful to Search Teams, should the need arise. Providing the information in advance of the need will allow Search Management Personnel to have the necessary information to establish a more effective search response.

Client: ____

Address: ____

City: ____Zip: ____________________

Phone: ______________________________

Date of Birth: __________________ Sex: ☐Male ☐Female Race: _______________

Nickname(s):____

Name of Spouse: ____

Diagnosis: ____

____

Caregiver(s)

Name: ____Phone: ________________

Address: ____

Relationship to Client: ____

Name: ____ Phone:_________________

Address:____

Relationship to Client: ____

Other persons the client might contact: ____

Physical Description

Height:______ ft ________in. Weight: ______________ Build:________________________

Hair Color: _______________ Hair Style: ___________________ Eye Color: ________________

Complexion: ___________________________________

Distinguishing marks, scars, tattoos. Describe: ____

____

General Appearance: ____

If client does not understand English, what language is understood? ________________________

Does client wear glasses? ☐Yes ☐No Does client wear hearing aid(s)? ☐Yes ☐No

Does client use: ☐Cane ☐Walker Does client go out alone? ☐Yes ☐No Explain:

____

____

Health Condition

Any known physical handicaps? ____

Any known medical problems? ____

List medications taken regularly and dosage: ____

____

Attending Physician: ____ Phone: _________________

Experience

Has client ever wandered off? ☐Yes ☐No When? ___________________________________

Where? ____

Located by searchers or returned home on own? ____

____

Habits

Interests: ____

☐Outgoing ☐ Quiet Likes groups or would rather be alone: _________________________

Which family member is client closest to?____

Client is afraid of:

Dogs? ☐Yes ☐No The dark? ☐Yes ☐No

Noises? ☐Yes ☐No People? ☐Yes ☐No

Other (explain)? ____

What actions does client take when hurt or frightened? (cry, shout, etc.)__________________

____

Will client talk to strangers? ☐Yes ☐No

Is client dangerous to himself/herself or others? ☐Yes ☐No

If Alzheimer's Disease or Dementia has been diagnosed, please answer the following:

Does client remain oriented to time and person? ☐Yes ☐No

Does client recognize familiar persons and faces? ☐Yes ☐No

Can the client travel to familiar locations? ☐Yes ☐No

Does the client sometimes clothe himself/herself improperly? ☐Yes ☐No (shoes on wrong foot, underwear over clothing, etc.)

Does client remember own name and the names of spouse and/or children? ☐Yes ☐No

How well does the client communicate verbally? ☐None ☐Poor ☐Fair ☐Good ☐Excellent

Personal Articles Normally Carried by Client

Tobacco products: ☐Yes ☐No Candy / Gum: ☐Yes ☐No

Matches: ☐Yes ☐No Lighter: ☐Yes ☐No

Food items: ____

Cash? Amount: ________________ Where carried? _________________________________

ID Bracelet? ☐Yes ☐No