# Resident Profile and Activity Information

Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Current Age: \_\_\_\_ Former Occupation(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years of School: \_\_\_\_\_ Number of Children: \_\_\_\_\_\_\_ Number of Grandchildren: \_\_\_\_\_\_\_\_\_ Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_

# Personal Information

Approximate time resident gets up in the morning? \_\_\_\_\_\_\_\_\_ Routine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Approximate time resident goes to bed at night? \_\_\_\_\_\_\_\_\_ Routine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant (check all that apply):

 \_\_\_\_ Sleeps Through the Night \_\_\_\_ Awake Most of the Night

 \_\_\_\_ Wanders Around at Night \_\_\_\_ Becomes Aggressive at Night

Does the applicant smoke? \_\_\_ Yes \_\_\_ No Drink alcohol? \_\_\_ Yes \_\_\_No (# drinks/day:\_\_\_)

**Eyesight:** Applicant wears: \_\_\_ Eyeglasses at all times \_\_\_\_Eyeglass to read \_\_\_\_ Contacts Requires large print: \_\_\_\_Yes \_\_\_No Last eye appointment was: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hearing:** Applicant: is hard of hearing \_\_\_Yes \_\_\_No Has no difficulty hearing \_\_\_Yes \_\_\_No

Wears hearing aides: \_\_\_ Yes \_\_\_No Last professional ear cleaning was: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dentition:** Applicant: wears dentures or partial \_\_\_Yes \_\_\_ No If yes: \_\_\_ top \_\_\_ bottom

Has broken/decaying teeth \_\_\_ Yes \_\_\_ No Has difficulty chewing/swallowing \_\_\_ Yes \_\_\_ No Last dentist appointment was: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Status:** Applicant is: (N) Never (S) Sometime (A) Always

 \_\_\_\_ Confused \_\_\_\_ Disoriented \_\_\_\_ Forgetful \_\_\_ Aggressive

 \_\_\_\_ Depressed \_\_\_\_ Wanders \_\_\_\_ Agitated \_\_\_ Anxious

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

**Behaviors:** Does the applicant sun down? \_\_\_ Yes \_\_\_ No If yes, what time? \_\_\_\_\_\_\_\_\_\_\_\_\_

What techniques work well for the applicant when frustrated/agitated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Does the applicant have any prn (as needed) medications for agitation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the applicant see a gero psychiatrist? \_\_\_ Yes \_\_\_ No If yes, who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last gero psychiatrist appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the applicant ever been admitted to a gero psych unit? \_\_\_ Yes \_\_\_ No When: \_\_\_\_\_\_\_\_\_\_

**Ambulation**

Applicant (check all that apply):

 \_\_\_\_ Is ambulatory \_\_\_\_ Uses Walker \_\_\_\_ Uses Cane \_\_\_\_Uses Wheelchair

 \_\_\_\_ Needs verbal cues to transfer from bed to chair

 \_\_\_\_ Needs physical assistance from one person to transfer from bed to chair

 \_\_\_\_ Needs physical assistance from two or more people to transfer from bed to chair

 \_\_\_\_ Needs supervision while ambulating

Has the applicant fallen in the past 90 days? \_\_\_ Yes \_\_\_ No If yes, how many times? \_\_\_\_\_\_\_\_

# Activities of Daily Living

**Dressing and Undressing:** Applicant is Independent \_\_\_ Yes \_\_\_ No Applicant requires (check all that apply):

 \_\_\_ Verbal Cues \_\_\_ Minimal Assist \_\_\_ Total Assist \_\_\_\_Reminders

**Incontinences:** Applicant:

 \_\_\_\_Is Continent \_\_\_\_ Is Seldom Incontinent \_\_\_\_ Is Incontinent at Night Only

 \_\_\_\_ Wears Pull Ups \_\_\_\_ Wears Pads \_\_\_\_ Is Incontinent Day and Night

 \_\_\_\_ Wears Pull Ups Only at Night \_\_\_\_ Wears Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Toileting:** Applicant is Independent \_\_\_ Yes \_\_\_ No Applicant requires (check all that apply):

 \_\_\_ Verbal Cues \_\_\_ Minimal Assist \_\_\_ Total Assist \_\_\_\_ Reminders \_\_\_ Reminders at Night Only \_\_\_ Staff Assist at Night Only

Overnight Use of Bathroom:\_\_\_\_Self \_\_\_\_Wake up Reminders \_\_\_Staff Assist

**Brushing Teeth:** Applicant is Independent \_\_\_ Yes \_\_\_ No Applicant requires (check all that apply):

 \_\_\_ Verbal Cues \_\_\_ Minimal Assist \_\_\_ Total Assist \_\_\_\_Reminders

**Medication:** Can Self-Administer \_\_\_ Yes \_\_\_ No Difficulty Swallowing Pills \_\_\_Yes \_\_\_No

Applicant requires (check all that apply):

\_\_\_ Verbal Cues \_\_\_ Crush Medication \_\_\_Meds in applesauce

Applicant requires use of an oxygen concentrator? \_\_\_ Yes \_\_\_No Portable tank \_\_\_Yes \_\_\_No

# Diet

Does the Applicant Eat Breakfast in the Morning? \_\_\_ Yes \_\_\_No Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the Applicant Eat Lunch in the Afternoon? \_\_\_ Yes \_\_\_ No Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Typical Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the Applicant Eat Dinner in the Evening? \_\_\_ Yes \_\_\_ No Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Likes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Dislikes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the Applicant has any food preferences (Religious or other): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the Applicant on a therapeutic diet (cardiac, low sodium, diabetic, etc) \_\_\_Yes \_\_\_No

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Require assistance with feedings? \_\_\_\_Yes \_\_\_\_ No Thickened Beverages \_\_\_ Yes \_\_\_ No

Does the Applicant currently take a nutritional supplement (Ensure, Boost)? \_\_\_Yes \_\_\_ No

# Interests/Hobbies

Prefers group activities \_\_\_\_ Yes \_\_\_\_ No Prefers Individual Activities \_\_\_\_ Yes \_\_\_\_ No Applicant is Interested In the Following (check all that apply):

 \_\_\_\_ Crafts \_\_\_\_Dancing \_\_\_\_ Musical Talent \_\_\_\_Sewing

 \_\_\_\_ Gardening \_\_\_\_Painting \_\_\_\_Needlework \_\_\_\_ Current Events

 \_\_\_\_Bingo \_\_\_\_Books \_\_\_\_ Movies \_\_\_\_\_ Spiritual Activities

 \_\_\_\_ Magazines \_\_\_\_ Poetry \_\_\_\_ Sports \_\_\_\_ Cooking/Baking

 \_\_\_\_ Bowling \_\_\_\_ Fishing \_\_\_\_ Music \_\_\_\_ Flower Arranging \_\_\_\_ Cards \_\_\_\_ Exercise \_\_\_\_ Puzzles \_\_\_\_ Discussion Group

 \_\_\_\_Animals \_\_\_\_ Outings \_\_\_\_ Board Games \_\_\_\_Children

 \_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Strengths: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weaknesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Comments

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