Seniors' Resource Center Adult Day and Respite Services

INTAKE PROFILE

Participant Name: ___________________________ **Date of Birth:** ____________ **Today's Date:** __________

Diagnosis: ____

____

Medical:

Allergies: Yes ☐ No ☐ If Yes, Type of Allergies:____

Medications: Yes ☐ No ☐
Taken at Program: Yes ☐ No ☐ Self Administers: Yes ☐ No ☐ If No, what type of assistance is required? Crush Meds ☐ Takes with Food ☐ Takes when handed ☐

Tube Feeding: Yes ☐ No ☐ Type of Tube Feeding: ____

Oxygen: Yes ☐ No ☐ Liters/Min: ____________

Additional Comments : ____

____

____

Transfer/Ambulation:

Transferring: Independent ☐ Supervision ☐ Assist ☐ Wheelchair to chair ☐

Ambulation: Independent ☐ Supervision ☐ Assist ☐
Mechanical Assist: Cane ☐ Walker ☐ Wheelchair ☐

Falls: Yes ☐ # in last 6 months: _______ No ☐

Additional Comments: ____

____

____

Bathrooming:

Assistance: Pants up/down ☐ Cleansing/wiping ☐ Changing ☐ Hand washing ☐
Transfer ☐ Supervision to and from bathroom ☐ Other ☐ ___________________

Bladder Control: Continent ☐ Incontinent ☐ Occasional Accident ☐

Bowel Control: Continent ☐ Incontinent ☐ Occasional Accident ☐

Depends: Small ☐ Medium ☐ Large ☐ X-Large ☐ Does not wear ☐

Pads: Poise pad ☐ Panty liner ☐

Additional Comments: ____

____

____

Dietary: Type of diet: Regular ☐ No Added Salt ☐ Ground ☐ Pureed ☐

Swallowing Difficulty ☐ Thickened Liquid ☐
Type of thickening: Honey Consistency ☐ Nectar Consistency ☐
Pudding Consistency ☐

Diabetic ☐
Low Sugar Diet ☐ Regular Diet ☐
Uses Oral Medication ☐ Insulin Dependent ☐
Range of expected glucose readings during the day ___________________________________
Glucose reading requiring medical attention (per Dr.) _________________________________

Food Allergies: ☐ No ☐ Yes List Allergies:____

Appetite: Good ☐ Fair ☐ Poor ☐

Assistance: Independent ☐ Assistance with Eating ☐ Cut up food ☐
Verbal Encouragement to Eat ☐ Other ☐______________

Dentition: Has own teeth ☐ Dentures ☐: Full/Partial Upper/Lower/Both

Comments: ____
____
____

Sleep Pattern: Sleeps well at night☐ Wakes frequently at night ☐

Typically, our goal is to keep participants awake and active throughout the day. However, we realize that people may require a nap or rest period while at the program. Please indicate how you would like us to respond if your loved one falls asleep.____
____
____

Mental Status/Behavior:

Decision Making Ability: Independent ☐ Needs Assistance ☐ Moderately Impaired ☐
Severely Impaired ☐

Short-term memory: Good ☐ Fair ☐ Poor ☐
Long-term memory: Good ☐ Fair ☐ Poor ☐

Wander Potential: Yes ☐ No ☐ In Building—High Risk ☐ Mod. Risk ☐ Low Risk ☐
Out of Building—High Risk ☐ Mod. Risk ☐ Low Risk ☐

Behaviors: Pacing ☐ Hoarding ☐ Disruptive ☐ Aggressive to Self/Others ☐
Repetitive Questions ☐ Interrupts Frequently ☐ Smokes ☐

What upsets: ____
____

What helps to calm: ____
____

Comments: ____
____

Attitude:

Enthusiastic ☐ Cooperative ☐ Cheerful ☐ Depressed ☐ Uncooperative ☐
Withdrawn ☐ Dwells on illness/other problems ☐

Attitude to life and activities in general: Interested ☐ Disinterested ☐

Sensory Capabilities:

Vision: Good ☐ Fair ☐ Poor ☐ Wears Glasses ☐

Hearing: Good ☐ Fair ☐ Poor ☐ Wears hearing aids-- L R Both

Communication:

Able to Make Needs Known ☐ Need to anticipate needs ☐ Able to Converse ☐

Making self understood: Understood ☐ Usually understood ☐
Sometimes understood ☐ Rarely/never understood ☐

Ability to understand others: Understands ☐ Usually understands ☐
Sometimes understands ☐ Rarely understands ☐

Speaks another language ☐ If so, what language(s)? ______________________________

Comments:____
____
____

Additional Information:____
____
____
____
____

Information obtained from:____

Relationship to participant:____

Reviewed by SRC Staff: ____ Date ___________