FAMILY QUESTIONNAIRE

Date _____

BACKGROUND INFORMATION

Resident Name _____

Age _____ Date of Birth ____/____/____

Place of Birth _____

Level of Education Completed _____

Former Occupations _____

_____

_____

_____

_____

Marital Status:

❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Number of Children _____ Male: ____ living ____ deceased

Female: ____ living ____ deceased

Prior Living Situation (home, another facility) _____

_____

_____

Does your relative have a memory problem? ❑ Yes ❑ No

How Long Has Your Relative Had a Memory Problem?

❑ 1 year ❑ 1-3 years ❑ 3-5 years ❑ 5 years or more

Was the Onset of the Problem: ❑ Sudden ❑ Gradual

Have there been any changes in your relative's mood or behavior in the last six months (i.e., falling, increased confusion, mood changes)?

❑ No ❑ Yes, explain _____

_____

_____

_____

_____

_____

_____

Does Your Relative Have a History of:

Smoking ❑ Yes ❑ No ❑ Unknown
If yes, specify cigarettes, cigars, pipe etc., and average useage _____

Alcohol Use ❑ Yes ❑ No ❑ Unknown
Explain: _____

Drug Use ❑ Yes ❑ No ❑ Unknown
If yes, specify type and quantity _____

Psychiatric Illness ❑ Yes ❑ No ❑ Unknown

CURRENT ABILITIES

Check (✓) areas that accurately describe your relative at this time. Give details as to frequency of the situation and how this impacts your relative.

✓	ORIENTATION	DETAILS
	Unaware of day or date	
	Doesn't know home is where they live	
	Wandering or getting lost	
	Trouble remembering events:	DETAILS
	Childhood	
	Middle years	
	Later years (retirement)	
✓	**RECOGNITION**	**DETAILS**
	Unable to recognize self	
	Unable to recognize familiar people	
	Unable to recognize familiar surroundings (neighborhood)	
✓	**COMMUNICATION**	**DETAILS**
	Unable to write	
	Unable to read	
	Unable to communicate needs clearly	
	Experiences word finding difficulty	
	Unable to communicate basic needs	
	Unable to understand simple directions	
	Unable to understand any directions at this time	
✓	**CONCENTRATION**	**DETAILS**
	Unable to complete tasks	
	Difficulty concentrating on a task	
	Gets up frequently and leaves task or meal	
✓	**AMBULATION**	**DETAILS**
	Loss of balance or falling when walking	
	Unusual gait (shuffling, leaning, fast pacing)	
	Has difficulty sitting in a chair	
	Bumps into things (walls, furniture)	
	Do you sometimes have to assist them in walking?	

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

ACTIVITIES OF DAILY LIVING

Codes: 1. Independent
2. Needs Supervision (cueing, encouragement, prompting)
3. Needs Some Physical Assistance
4. Totally Dependent

Check appropriate number	1	2	3	4

Ability To Feed Self
Helpful ways to assist _____
_____
_____
Adaptive devices needed: ❑ No ❑ Yes
If Yes, devices used _____
_____

Ability To Dress Self
Helpful ways to assist _____
_____
_____
Need for special clothing: ❑ No ❑ Yes
If Yes, explain _____
_____
_____

Ability To Toilet Self
Helpful ways to assist _____
_____
_____
Is continent of bowels:
❑ Always ❑ Sometimes ❑ Never
Concerns/Needs (constipation, loose stools colostomy, etc.)
_____
_____
Is continent of bladder:
❑ Always ❑ Sometimes ❑ Never
Concerns/Needs _____
_____

Ability To Do Dental Care
Helpful ways to assist _____
_____
_____

Ability To Bathe Self
Prefers: ❑ Bath ❑ Shower
Time of day _____
Frequency (per week) _____
Helpful ways to assist _____
_____

ACTIVITIES OF DAILY LIVING (cont'd)

	1	2	3	4

Ability To Wash Own Hair
Washes:
❑ In shower ❑ In sink ❑ At beauty shop
❑ Other _____
Helpful ways to assist _____
_____
_____

Ability To Shave Self
❑ Razor ❑ Electric razor
Helpful ways to assist _____
_____
_____

Ability To Use Make-Up
Still likes to use: ❑ No ❑ Yes
Helpful ways to assist _____
_____
_____

SLEEP PATTERNS

Sleeps through the night: ❑ No ❑ Yes
Frequently awakes at night: ❑ No ❑ Yes
Sleeps during the day: ❑ No ❑ Yes
Nap time(s): _____
Usual time to arise _____
Usual time to retire _____
Sleep related concerns/needs _____
_____
_____
Helpful ways to assist _____
_____

SENSORY/DENTAL

	Yes	No
Does your relative have vision difficulties?		
Use glasses?		
Contact lenses?		
Concerns/Needs _____		
Does your relative have hearing difficulties?		
Use hearing aid?		
Concerns/Needs _____		
Does your relative have own teeth?		
Have dentures?		
❑ Upper ❑ Lower ❑ Partial		
Concerns/Needs _____		

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DIETARY

	Yes	No	Some Times	Time Of Day
Does your relative:				
Eat breakfast?				
Eat lunch?				
Eat dinner?				
Snack?				
Is your relative:				
Able to feed self?				
Able to swallow without choking?				
Able to use regular utensils?				
Has your relative had a:				
Significant weight loss in last 3 months?				
If Yes, how much: _____				
Significant weight gain in last 3 months?				
If Yes, how much: _____				

Preferred fluids:

Breakfast _____

Lunch _____

Dinner _____

Between meals _____

Favorite foods:

Breakfast _____

Lunch _____

Dinner _____

Between meals _____

Food dislikes/intolerances (i.e., chocolate, milk, eggs):

_____

_____

Food allergies:

_____

_____

Foods that help relieve:

Constipation _____

Loose stool _____

Behaviors which indicate hunger:

_____

_____

Does eating change your relative's mood?

❑ Yes ❑ No

If Yes, explain _____

_____

MOOD AND BEHAVIOR

Check (✓) all behaviors that apply AND Check (✓) the appropriate code number.

Codes: 1. Behavior occurs less than daily
2. Behavior occurs daily or more frequently

(✓)		(✓) 1	(✓) 2
	Wandering		
	Continuous pacing		
	Repetitive behaviors (words, actions)		
	Withdrawn/depressed (long periods of time inactive)		
	Appears anxious, worried, nervous, fearful		
	Crying, tearful		
	Comments about death of self or others		
	Sleep disturbances (insomnia, or frequent napping)		
	Mood swings (sudden changes in mood)		
	Overeating		
	Undereating		
	Clinging (to caregiver, can't leave sight)		
	Verbally abusive (curses, screams, threatens)		
	Physically abusive (strikes out)		
	Rummaging or hoarding (goes through things or hides things)		
	Inappropriate toileting habits		
	Inappropriate sexual behavior		
	Sundowning behavior (difficult behaviors or increased confusion occurs in late afternoon)		
	Hallucinations (hears or sees things that are not there)		
	Delusions (tells stories that are not fact based)		
	Suspiciousness		
	Resistant to care		
	Repetitive verbalizations or behaviors		
	Catastrophic reactions (overreacts to stressful situations)		
	Boredom _____		
	Other _____		
	Other _____		

BEHAVIOR RELATED CONCERNS/COMMENTS

_____

_____

_____

_____

_____

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PERSONAL INFORMATION TO INDIVIDUALIZE CARE

1. What type of leisure/social/religious activities has your relative enjoyed in the past?

_____

_____

2. What type of leisure/social/religious activities can/does your family member still enjoy doing?

_____

_____

3. Are there situations that upset or trigger a behavior with your relative?

❑ Car rides ❑ Being alone ❑ Unfamiliar surroundings ❑ Demands (personal care)

❑ Being touched ❑ Other _____

4. Do you have interventions you use to help calm your relative?

❑ Humor ❑ Affection ❑ Food (snack) ❑ Going for a walk ❑ Leaving alone

❑ Other _____

5. Does your relative experience routine or occasional discomfort due to a physical condition (headaches, joint pain)? _____

_____

6. Clues that may indicate your relative is experiencing pain or illness (verbal or non-verbal). _____

_____

7. Are there life experiences or accomplishments your relative enjoys recalling?

Childhood _____

_____

Middle years _____

_____

Retirement _____

_____

8. Were there unpleasant life experiences which your relative still recalls, and of which staff needs to be aware and sensitive? Please indicate how to respond, i.e. do not bring up, etc.

Childhood _____

_____

Middle years _____

_____

Retirement _____

_____

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DAILY ROUTINE

INSTRUCTIONS: Describe what your relative's typical day consists of. Include meals, naps and snacks as well as activities such as walks, TV, helping with chores and maintaining own business affairs.

Signature of Family Member/Significant Other _____ Date _____

Relationship _____ Date _____

Signature of Interviewer _____

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