Client Questioniare

Please take a few minutes to fill out this short survey. If you are filling out this survey for someone else, please answer the questions as if you were the client. Each question defines abilities by function. Please select only one answer for each task. We appreciate your time!

*1. Please add the clients full name, email and phone number. If you are the primary contact for the client, please add your name and contact information to contact info, below the client's information. NOTE: Your email address and phone number will not be shared or used for any other purpose than to communicate with you regarding Senior Home Transitions.

First and Last Name:

Email Address:

Phone Number:

Care Giver's Name:

Care Giver's Phone Number:

*2. How would you categorize current cognitive functions?

- No issues beyond normal forgetfulness
- Memory loss can be detected by close friends and family
- Poor judgement can be detected by close friends & family, memory loss is obvious. I cannot remember things outside the daily routine (appts & holidays)
- Unable to remember how to complete some routine tasks. Poor judgement and memory loss is obvious
- Unable to complete most routine tasks is not oriented to person or place, may wander, cannot be left alone
- I don't know

Other (optional--please specify)

*3. How would you describe client abilities as it relates to driving a car?

- Drives independently
- Drives short distances only or uses public transportation
- Travels outside the house with the assistance of another person
- Travels outside of the home is a big effort
- Unable to travel, confined to the home
- I don't know

Other (optional--please specify)

*4. How would you describe your abilities as it relates to shopping?

- Shops independently
- Shops independently but only for small purchases
- Shops with the help of another person
- Unable to shop but can give instructions to another person
- Unable to participate with regard to shopping
- I don't know

Other (optional--please specify)

*5. How would you describe client abilities as it relates to eating a meal?

- Able to maintain healthy eating habits and prepare meals
- Able to maintain healthy eating habits by purchasing prepared meals and snacks
- Needs assistance of another person to make food available and ready to eat
- Needs some assistance of other person to eat a meal, cutting food, encouragement
- Needs complete assistance of other person to eat a meal; place food on utensils and/or feeding
- I don't know

Other (optional--please specify)

*6. How would you describe client abilities as it relates to medications?

- Manages all medications independently
- Has been known to forget medications occasionally
- Requires daily reminders to take medications
- Needs someone to make medications available at the right time of day
- Needs assistance handling and swallowing medications
- I don't know

Other (optional--please specify)

*7. How would you describe risk of falling down?

- Has virtually no safety issue while living independently at home
- Suspect some safety issues due to unsteadiness or bad balance
- Needs a cane or walker and I have successfully prevented or limited falls
- Has had frequent falls, even with cane or walker
- Will fall if not supported by another person
- I don't know

Other (optional--please specify)

*8. How would you describe client abilities as it relates to taking a bath?

- Bathes independently
- Bathes independently, perhaps with special equipment. I prefer someone to be close by for safety
- Can bathe with some assistance from another person to get in/out of tub, dry off, etc.
- Needs considerable assistance with bathing from another person but can help with the task
- Completely dependent on another person. This activity is limited to a few days per week
- I don't know

Other (optional--please specify)

*9. How would you describe client abilities as it relates to getting dressed?

- Can dress independently
- Can dress with some assistance from another person to handle buttons, zippers, shoes
- Needs considerable assistance with dressing from another person but can help with the task
- Is completely dependent on another person. This activity is limited; only changes clothes when necessary.
- I don't know

Other (optional--please specify)

*10. How would you describe client abilities as it relates to getting up and down?

- Is able to get in and out of a chair or without much effort
- Is able to get in and out of a chair or bed with substantial effort
- Is unable to get in and out of a chair or bed with the help of special equipment such as a walker or special furniture
- Is unable to get in and out of a chair or bed without some assistance from another person
- Is unable to get in and out of a chair or bed without complete assistance from another person. May be bed bound
- I don't know

Other (optional--please specify)

*11. How would you describe client abilities as it relates to going to the bathroom?

- Is able to maintain all toileting needs
- Is able to maintain all toileting needs by using special equipment such as raised toilet seat or grab bars
- Is able to maintain all toileting needs by using special equipment and by using incontinence undergarments
- Is unable to maintain toileting without assistance from another person. Able to control need to toilet for 3-4 hours
- Is unable to maintain all toileting needs without assistance from another person. Unable to control need to toilet
- I don't know

Other (optional--please specify)

*12. What areas of town are you interested in?

- East End
- South End
- Downtown
- St. Matthews
- West End
- It doesn't matter

Other (optional--please specify)

*13. What type of accommodations would you prefer?

- Single Family Adult Care Group Home (up to 6 residents)
- Residential Facility
- Continuing Care Retirement Community

Other (optional--please specify)

*14. Do you have Long term care insurance

- Yes
- No

*15. Would you prefer a shared or private room if finances allow a choice?

- Private
- Shared

Other (optional--please specify)

*16. Do you have special diet requirements?

- Yes
- No

Other (optional--please specify)

*17. Will you want a pet?

- Yes
- No

Other (optional--please specify)

*18. How would you describe your desire for an outdoor patio?

- Extremely Important
- Very Important
- Important
- Somewhat Important
- Not Important

Other (optional--please specify)

*19. How would describe your desire for outdoor activities?

- Extremely Important
- Very Important
- Important
- Somewhat Important
- Not Important

Other (optional--please specify)

*20. How would describe your desire for smoking accomodations?

- Extremely Important
- Very Important
- Important
- Somewhat Important
- Not Important
- I don't smoke
- I don't want to be in a facility that allows smoking

Other (optional--please specify)

*21. How would describe your desire for availability for alcohol?

- Extremely Important
- Very Important
- Important
- Somewhat Important
- Not Important
- I don't drink
- I don't want to live in a place where alcohol is available

Other (optional--please specify)