Samaritan

Getting To Know You

Resident Name:_____**Date:**_____

Our goal is to help you reach or maintain your optimum level of independence. Please answer these questions in light of your current abilities and preferences. Please complete this form and return it to the SKH Registration Desk (located in the SKH Lobby).

Check all items in each category that describe your abilities and leave blank those items that do not apply to you.

Dressing (how do you dress yourself)

- _ I can get my own clothing out of the closet/dresser
- _ I can put my clothing on without assistance
- _ I can put my shoes on without assistance
- _ I can manage buttons and zippers without assistance

COMMENTS:_____

<u>Bathing and Grooming:</u>

- _ I can get in and out of tub/shower by myself
- _ I can bathe/shower independently
- _ I need assistance washing certain areas on the body
- _ I can comb my hair without assistance
- _ I can brush my teeth/perform denture care independently
- _ I can shave independently

COMMENTS:_____

Which do you prefer: _____Bath _____Shower?
What time do you prefer to bathe:_____

<u>Dining:</u>
What time do you usually eat breakfast:_____
What do you generally eat for breakfast:_____

What time do you usually eat lunch:_____
What do you generally eat for lunch:_____
What is the most substantial meal of the day:_____
Do you have a good appetite?_____
Do you snack between meals?_____
What do you prefer as a snack?_ Morning_____
Afternoon:_____
Evening:_____
Have you had a recent wt change?_____ **if yes, explain**_____

Do you like to cook?_____
Do you prefer to eat :_____alone ? _____with others?
How do you take your coffee/Tea?_____
Preferred condiments:_____

Walking:
I can walk with no assistive devices:_____
I can walk independently with :_____Cane _____walker
I can walk if someone is with me to ensure my safety;_____
I can walk short distances (less than 50 feet):_____
I can walk long distances:_____
I enjoy taking regular walks:_____
I am independent in my wheel chair:_____

COMMENTS:_____

Transferring:
_ I can get out of and into bed on my own
_ I can go from the bed to a chair and visa versa with no assistance
_ I need assistance to get in and out of bed or a chair
_ I need total assistance with transfers

COMMENTS:_____

Toileting:
_ I can toilet myself without assistance
_ I need a raised toilet seat
_ I can care for myself after toileting
_ I am continent, but need assistance with hygiene
_ I am incontinent, but use protective pads and can change them myself
_ I am incontinent but need assistance with incontinence products.

COMMENTS:_____

Pain Assessment:
Do you have any pain?_____
Where is your pain?_____
Is pain of such intensity that it limits your ability to be independent in your care?_____
When do you experience pain ?_____
What do you do to alleviate the pain?_____ Medication: _____hot /cold packs _____Topical ointments _____Other?_____

Is the treatment you use effective?_____
How long are you pain -free before requiring more treatment?_____

Daily Routine:
What time do you wish to get up in the morning?
What time do you wish to get dressed in the morning?
Do you nap during the day?_____ if yes, at what time ?_____ for how long?_____.
What time do you go to bed at night?_____

Do you generally sleep thought the night?_____. If no, do you awaken to use Bathroom?_____, How many times do you get up at night to use Bathroom?_____

In your present bedroom, is one side of your bed placed against the wall?_____ if yes, which side (as you are laying in bed) is against the wall_____

Do you have someone come in during the day or night to assist with meal preparation, household chores ,personal care, etc._____ if yes, Who:_____

COMMENTS:_____

_____

Which of the following do you do during a typical day

- _ Go out (shopping ,visiting, etc)
- _ Watch T.V. (Favorite shows?_____)
- _ Read
- _ Crafts
- _ Hobbies(Specify:)_____
- _ Other (Specify):_____

When do you prefer to take your medications?_____

With meals ?_____before meals?_____ after meals?_____

If you have diabetes, what is your Normal blood sugar range?_____

Activities:

Occupation:_____

Specific interest:_____

Do you participate in any community/church organizations?_____

Are there any activities in which you participate at least weekly:?_____

Do you prefer to :

- _ Socialize in small groups
- _ Socialize in larger groups
- _ Pursue solitary activities
- _ No preference

Do you belong to any particular church or synagogue?_____

Do you find strength in religion?_____

Do you vote in local, state and national elections?_____

Is there anything else you would like to share about yourself that would help our staff meet your needs?_____

_____

_____

Thank you for taking time to fill out this questionnaire!!!