Project Lifesaver Client Profile

Personal Data Questionnaire

This form is designed for caregivers to provide, in advance, certain information that will be useful to Search Teams, should the need arise. Providing the information in advance of the need will allow Search Management Personnel to have the necessary information to establish a more effective search response.

CLIENT INFORMATION:

Name: _____
Address: _____
City & Zip: _____
Phone number(s): _____
Date of Birth: _____ Sex ☐ Male ☐ Female Race _____

Nickname(s): _____
Name of Spouse: _____
Diagnosis: _____

CAREGIVER(S) INFORMATION:

Name: _____ Phone _____
Address: _____
Email Address: _____
Relationship to Client: _____

Name: _____ Phone _____
Address: _____
Email Address: _____
Relationship to Client: _____

Other persons the client might contact: _____

PHYSICAL DESCRIPTION

Height:		Weight:		Build:	
Hair Color:		Hair Style:		Eye Color:	
Complexion:					
Briefly describe any distinguishing scars, marks or tattoos:					

General Appearance: _____

If client does not understand English, what language is understood? _____

Does client wear glasses? ☐Yes ☐No Does client wear hearing aid(s) ☐Yes ☐No

Does client use: ☐Cane ☐ Walker Does client go out alone? ☐ Yes ☐No

Explain: _____

HEALTH CONDITION

Any known physical handicaps? _____

Any known medical problems? _____

List medications taken regularly and dosage:

_____

Attending Physician: _____ Phone: _____

EXPERIENCE

Has client ever wandered off? ☐Yes ☐No

When? _____

Where? _____

Located by searchers or returned home on own? _____

HABITS

Interests: _____

☐Outgoing ☐Quiet Likes: ☐ Groups ☐ Would rather be alone

Which family member is client closest to? _____

Client is afraid of:

Dogs ☐Yes ☐No The dark ☐ Yes ☐No Noises ☐ Yes ☐No People ☐Yes ☐No

Other (explain)? _____

What actions does client take when hurt or frightened? (cry, shout, etc?)	

Will client talk to strangers? ☐ Yes ☐No

Is client dangerous to himself/herself/others? ☐ Yes ☐ No

PERSONAL ARTICLES NORMALLY CARRIED BY CLIENT

Tobacco products: ☐Yes ☐ No Candy/Gum: ☐ Yes ☐ No

Matches: ☐Yes ☐ No Lighter: ☐ Yes ☐No

Food items: _____

ID Bracelet? ☐ Yes ☐No

Cash? Amount: _____ Where carried? _____

If Alzheimer's Disease or Dementia has been diagnosed, please answer the following:

Does client remain oriented to time and person? ☐Yes ☐ No

Does client recognize familiar persons and faces? ☐ Yes ☐ No

Can the client travel to familiar locations? ☐Yes ☐No

Does the client sometimes clothe himself/herself improperly? ☐Yes ☐No (shoes on wrong foot, underwear over clothing, etc.)

Does client remember own name and the names of spouse and/or children? ☐Yes ☐No

How well does the client communicate verbally? ☐None ☐ Poor ☐ Fair ☐Good ☐ Excellent