JOY COMMUNITY COMPANY

Questionnaire

**Gail Gottinger**
**Certified Senior Advisor. CSA,**
**Owner**
**gail@joycommunitycompany.com**
**414-640-7650**

**Date:**

| **Name of Resident:** | | Gender: | Age: | Weight: |
|---|---|---|---|---|
| **Current Location:** | | | | |
| **Primary Contact:** | | Phone Number: | | |

**In general, how would you rate their health?**

| | | | |
|---|---|---|---|
| ☐ Very Good | ☐ Good | ☐ Fair | ☐ Poor |

**Does the resident have any of these health issues?**

| | | | |
|---|---|---|---|
| ☐ Kidney Problems | ☐ Diabetes | ☐ Stroke | ☐ Liver Problems |
| ☐ COPD (Lung Disease) | ☐ Heart Problems | ☐ Cancer | ☐ Alzheimer's/Dementia |

➢ **Please provide details on above health issue:**

☐ Other (Please Specify)

**Does the resident need assistance with any of the following?**

| | | | |
|---|---|---|---|
| ☐ Eating | ☐ Walking | ☐ Getting dressed | ☐ Getting in or out of a bed/chair |
| ☐ Using the toilet | ☐ Seeing | ☐ Hearing | ☐ Taking a bath/shower |

➢ **Please list all medications:**

| | | |
|---|---|---|
| Does resident currently smoke or use tobacco? | ☐ Yes | ☐ No |
| Any problems with balance or walking in the past 12 months? | ☐ Yes | ☐ No |
| How many falls in the past year? | ☐ (1-5) | ☐ (6+) |

| | | |
|---|---|---|
| Does resident have trouble sleeping at night? | ☐ Yes | ☐ No |
| How many times do they get out of bed at night? | ☐ (1-3) | ☐ (4+) |
| | | |
| Is resident ambulatory? | ☐ Yes | ☐ No |
| If incontinent, approximately how many times throughout the day? | ☐ (1-4) | ☐ (5+) |
| Can they bear their own weight? | ☐ Yes | ☐ No |

If you answered "NO" to the previous question. Please mark one of the following options.

| | | |
|---|---|---|
| ☐ 1 person assist | ☐ 2 person assist | ☐ Hoyer Lift |

**Does the resident have any behavioral issues?**

| | | | |
|---|---|---|---|
| ☐ Agitation | ☐ Aggressiveness | ☐ Combative | ☐ Yells at night |
| ☐ Refuses food/drink | ☐ Depression | ☐ Unsocial | ☐ Refuses medication |

- **Please provide any additional information:**

| | | | |
|---|---|---|---|
| **Does resident require a special diet?** | ☐ Yes | ☐ No | Please explain: |
| **Does resident have any allergies?** | ☐ Yes | ☐ No | |
| **Does resident have any recent infections?** | ☐ Yes | ☐ No | Be specific. Urinary Tract Infection? |

**Does the resident use any of the following?**

| | | | |
|---|---|---|---|
| ☐ Oxygen Catheter | ☐ Wheelchair | ☐ Hospital Bed | ☐ Walker/Cane |

Other:

***Disclaimer: This document is for informational purposes only. The intent is to provide additional information to the RCFE and not medical in nature. Stafford Senior Solutions is not a doctor nor licensed in medical. All answers were provided by either the resident or family members. Information and answers to the previous questions, should be verified by a medical assessment or consulted with a physician.