Legacy Home Care, LLC

FAMILY QUESTIONNAIRE

Your Name_____ Date _____

I. I would like assistance for my: Mother ___ Father ___ Both ___ Other (specify) _____

PLEASE NOTE: IF THE PERSON NEEDING HELP LIVES WITH A SPOUSE/CAREGIVER, PLEASE INCLUDE INFORMATION ON BOTH PARTIES AS MUCH AS POSSIBLE.

His/Her/Their Name(s) _____

_____

Address _____City_____State_____Zip_____

Birthdate(s) ___ /___ /___ ___ / ___ / ___ Birthplace(s) _____

S.S. #s: _____

Ethnic, racial or cultural background _____Education _____

Religion _____Active religiously? If so, where _____

Marital Status (circle one): Single Married Separated Divorced Widowed

Date of divorce or widowhood (if applicable) _____

Describe impact of this loss on relative _____

_____

Insurance Information

Medicare A _____ B _____ Medicare #(s) _____

Medigap Insurance: Provider _____Medigap Policy # _____

Does policy cover mental health benefits? Yes No

HMO _____HMO Policy # _____Phone (_____)_____

Do you have long-term care insurance?

Family Information

Relatives of person needing assistance Relationship

Name	Home phone,	
Address	Work phone,	
Name	Home phone,	
Address	Work phone,	
Name	Home phone,	
Address	Work phone,	

Name	Home phone,	
Address	Work phone,	
Name	Home phone,	
Address	Work phone,	

Who will take ongoing responsibility for talking with Care Manager: _____

Who will be responsible for payment of services provided by Legacy Nursing Focus?_____

List friends, neighbors and relatives who help your relative(s):

Name	Relationship
Address	Phone
Specifically, how does s/he help?	

Name	Relationship
Address	Phone
Specifically, how does s/he help?	

Name	Relationship
Address	Phone
Specifically, how does s/he help?	

List lawyer, accountant, significant others:

	Phone #:
Lawyer	
Power of Atty. (Finances)	
Power of Atty. (Healthcare)	
Significant other(s)	

How would you rate the present support system? Excellent ___ Good ___ Fair ___ Poor ___

Any recent problems with this support system?_____

_____

Which of these people would you or your relative(s) call in an emergency? _____

List in-home help, phone, and degree of satisfaction

	Phone/agency	Circle degree of satisfaction	Circle rate of Frequency
House cleaning		High Medium Low	Daily Weekly Monthly
Home aid(s)		High Medium Low	Daily Weekly Monthly
Other		High Medium Low	Daily Weekly Monthly

Describe type of living environment (circle appropriate descriptions)

Rent *Own* *Apartment* *House* *Condominium*

Adequacy of home environment (circle appropriate description)

Excellent *Fair* *Poor*

IV. Medical Information

List significant doctors and other health specialists the relative(s) sees now or has seen recently.

Name	Phone	For what problem…

Describe the most significant health problems, treatments, and medications:

Problem	Treatment	Medication

Date of last checkup_____ Known allergies _____

Recent hospitalization? Y N Describe reason and outcome _____

Describe relative's reactions to his/her own medical support system; describe your reactions to this system also. _____

V. Self-care and Daily Living Information

Check ✓ problem areas in daily living:

Driving		Bathing		Decision making	
Using other transportation		Dressing		Toileting	
Using telephone		Managing money		Transfer	
Preparing light meal		Taking medications		Walking	
Cleaning/laundry		House maintenance		Other	
Eating		Grocery shopping		Other	
Please explain:					

Which of the following are problems/risks? Please check ✓

Suicide ___ Drinking ___ Sleeping ___ Wandering ___ Setting Fire ___ Other _____

Who buys groceries, prepares meals? State if there are any nutritional concerns? _____

Summarize present capacity for self-care:_____

Memory, Orientation and Judgment

If any memory problems exist, how disabling are they? Consider, does your relative recognize you, the time, his/her location? Does s/he make sense most of the time? Has there been any recent long-term memory loss? Would you rate memory problems as mild, moderate, or severe? Is there a medical diagnosis and current treatment?

Emotional Health

Describe basic personality. How does your relative cope? Do you see him/her as dependent, anxious, withdrawn, content, lonely, or other?

Are you concerned about any recent changes in behavior or sense of well-being? If so describe. (What hints have you received lately?)

Does (do) your relative(s) share your same concerns or worries as stated above? Y N

Any history of emotional problems? Y N Past or present treatment? Y N

Has relative experienced recent losses of any kind (health, loved ones, job, etc.)? Describe impact.

Social Life

What is the extent of your relative's social life, interests? Do you feel it is satisfactory? Any significant changes? Does your relative feel satisfied? Please explain.

Work and Retirement

What was your relative's occupation or profession? _____ Date of retirement _____

How was the adjustment to retirement? Please describe.

VI. Other Pertinent Information

Hospital Preference _____ D.N.R. Order _____

Trust _____ Lifecare _____

Will _____ Living Will _____

Funeral Arrangements _____ Cemetery Plot _____

Are there financial problems? Please describe. _____

VII. Summary

Now that you have had time to outline this information, please tell us what your major concerns are and specifically what type of assistance you seek.

In your opinion, in what areas of life would your relative be accepting of help (i.e. help with personal chores, companionship, memory, personal problems)? Give this some thought, as this is key to the social worker's plan for a successful approach to your relative.