



Hearthside Assisted Living

1501 W 6th Avenue Sault Ste. Marie, MI 49783

Phone 906-635-6911

Fax 906-635-8399

E-mail: sunsetmanor_ssm@obcglobal.net

SCREENING QUESTIONNAIRE

Current Living Arrangement:

Name: _____

Please check all that apply:

- I live: in my own home/apartment
 senior housing
 with spouse
 with friend/significant other
 with family members
 alone

Care Needed:

Please check all that apply:

<u>TYPE</u>	<u>YES</u>	<u>NO</u>	<u>ASSISTANCE NEEDED</u>
1. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Preparation/Set up <input type="checkbox"/> Getting in/out of shower <input type="checkbox"/> Other
2. Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other
3. Wake up/Get out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> need to be awakened <input type="checkbox"/> Help to get out of bed <input type="checkbox"/> Dressing/undressing <input type="checkbox"/> Fasten clothes <input type="checkbox"/> socks/shoes <input type="checkbox"/> complete assistance
4. Preparing for bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> getting ready <input type="checkbox"/> getting into bed
5. Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> use protective garments <input type="checkbox"/> need help to change
6. Special Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diabetic <input type="checkbox"/> Low sodium <input type="checkbox"/> Low fat <input type="checkbox"/> Vegetarian <input type="checkbox"/> Other _____

Name: _____

7. Dining

___ ___

- ___ special utensils
- ___ assistance getting ready
- ___ assistance to get to and from dining room
- ___ likes to sit alone
- ___ likes to sit with others

Concerns about you:

Please list all current physical conditions you have (cancer, hypertension, etc.)

Do you have a doctor caring for any of these conditions?

Have you been diagnosed with dementia or Alzheimer's? YES _____ NO _____

Do you have trouble with forgetting things? _____

Are you nervous or anxious around other people? _____

Are you shy about getting to know strangers? _____

What are your favorite foods to eat? _____

What time of the day do usually eat meals and snacks? _____

List any other things you think are pertinent to your caregivers to make this residence your home, a place where you feel very welcome, comfortable and peaceful
