

Daughters of Sarah Nursing Center

Lifestyle Survey

Date of Interview: _____

Place of interview: _____

Interview completed by: _____

Information obtained from: _____

Applicant's Name: _____

Prefers to be called: _____

Codes:

I = independent S = supervision T = total care

A2 = assistance of 2 A1 = assistance of 1

Height: _____

Weight: _____

A. Eating:

Tube feeding Special needs _____

Supplements Food allergies _____

Risk factors:

chokes coughs impaired swallowing

needs encouragement to complete vision

Mental impairment other _____

Fluids:

As desired restricted needs strong encouragement

B. Skin Care:

- Good condition
- Reddened area(s) Location _____
- Special routine Location _____
- Rash Location _____
- Wound Location _____

Risk factor:

- Dry skin Low weight Incontinent
- Limited mobility Bedridden
- Disease process: _____

C. Ambulation:

Devices used:

- none walker cane
- quad cane brace other
- _____

D. Transfers:

- Hoyer lift Other _____
- _____

E. Paralysis:

- Hemiplegia rt leg rt arm
- Lt leg lt arm

Risk factors:

- Dizziness confused judgment
- S/P Stroke S/P Fracture impaired vision
- medication other _____
- _____

F. Dexterity:

left handed right handed

G. Mental Status:

alert oriented
person place time
confused agitated combative
hallucinations depressed mood/sad
wanders other _____

H. Grooming:

morning care _____ bedtime care _____ set up only
shaving _____ hair _____ nail _____
oral care _____ cosmetics _____

I. Dressing:

Set up only dressing _____ socks/shoes _____
chooses clothing _____ special items _____

J. Bathing:

Preference:

Bathtub in am
shower in pm

K. Toileting:

Bladder

continent incontinent
occasionally often always
wears incontinence product

Type: _____

Bowels:

- | | | | | | |
|---------------|--------------------------|-------------|--------------------------|------------|--------------------------|
| continent | <input type="checkbox"/> | incontinent | <input type="checkbox"/> | | |
| occasionally | <input type="checkbox"/> | often | <input type="checkbox"/> | always | <input type="checkbox"/> |
| uses bathroom | <input type="checkbox"/> | day time | <input type="checkbox"/> | night time | <input type="checkbox"/> |
| uses commode | <input type="checkbox"/> | day time | <input type="checkbox"/> | night time | <input type="checkbox"/> |
| uses urinal | <input type="checkbox"/> | day time | <input type="checkbox"/> | night time | <input type="checkbox"/> |
| uses bed pan | <input type="checkbox"/> | day time | <input type="checkbox"/> | night time | <input type="checkbox"/> |

Catheter:

- | | | | | | |
|------------|--------------------------|---------------|--------------------------|-----------|--------------------------|
| indwelling | <input type="checkbox"/> | straight cath | <input type="checkbox"/> | ileostomy | <input type="checkbox"/> |
| Colostomy | <input type="checkbox"/> | | | | |

L. Medications

(List all medications currently taking, doses, ect)

Medications

dose

frequency

M. Treatments

(List all treatment currently receiving)

<u>Treatment</u>	<u>Reason</u>	<u>Frequency</u>
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N. Therapies

(Indicate all therapy currently receiving)

<u>Therapy</u>	<u>Frequency</u>	<u>Provided By</u>
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P.T

O.T.

ST

O. Allergies:

NKA

Known allergies to: _____

P. Sensory:

hearing:

normal R L

impaired R L

wears hearing aide L R

refuses reads lips sign language

special device(s) used _____

can apply/remove device(s) by self

requires assistance with removal/application of device(s)

Q. Speech:

normal impaired aphasic
expressive receptive
primary language is English
speaks other language(s) in addition to English _____
language barrier _____

R. Vision:

normal impaired L_____ R_____
cataracts L_____ R_____
glaucoma
wears contacts Type _____
wears glasses Type _____
prosthesis worn Type _____

S. Oral Care:

Own teeth Yes No
Dentures upper Lower
Refuse Yes No
Partial bridge without teeth
Special mouth care can apply/remove oral devices by self
Requires assistance with application/removal or oral devices

T.

Additional information regarding care: _____

U.

Daily Routine:

(include regular routine, awakening, bedtime, sleeping patterns, daily activities, home care or health care providers, day program, ect. That will help us to enhance his/her stay at Daughters of DOS SSTC program:)

V. Hobbies/Personal interests:

Religious preference: _____

Practicing Yes No

Interested in attending services at DOS Yes No

W. Referral sources to contact for additional information:

(List referral agency (ies), contact person, duties, phone number).
