North End Senior Solutions
P.O. Box 148
Otis, OR 97368
541-921-0937

NESS Club

Participant/Care Receiver Information

Date _____

Care receiver's Name:_____ Date of Birth: _____

Primary Diagnosis: _____

Address: _____City: _____

ZIP:_____Phone: _____E-mail:_____

Primary Caregiver's Name:_____Relationship:_____

Address: _____City:_____

ZIP:_____Phone:_____E-mail: _____

Emergency Contact's Name #1: _____

Address:_____

City:_____ ZIP:_____Phone:_____

Emergency Contact's Name #2:_____

Address: _____

City:_____ ZIP:_____Phone:_____

Transportation Plans:_____

☐ I don't have a way to get there; needs transportation.

Income Level, ONLY if applying for scholarship or sliding-scale payment:

Size of family:_____ Yearly Household Income: (pick one) $0.00–$8,000☐ $8,050–$15,000 ☐

$15,050-$25,000 ☐ Over $25,000 ☐

Please complete the reverse side

Physician: _____ Date of last visit: _____

Address: _____ Phone: _____

Important Health History _____

_____

Special Diet: _____

Mental Health:

Forgetfulness/short-term memory: ☐ Yes ☐ No Confusion: ☐ Yes ☐ No

Has a diagnosis of Dementia or Alzheimer's disease been made? ☐ Yes ☐ No When? _____

Does the care receiver "wander"? _____ Or display inappropriate behavior? _____

When and how? _____

Additional Comments:

Does the care receiver mind being away from the caregiver? Explain:

Has the care receiver ever been violent or abusive? Explain:

Describe important physical conditions:

Is the care receiver incontinent? Bladder: ☐ Yes ☐ No Bowel: ☐ Yes ☐ No

Is the care receiver able to go to the toilet by his or herself? ☐ Yes ☐ No Has to be reminded? ☐

Does the care receiver need assistance to walk or move? Explain:

Are supportive devices used? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Scooter ☐ Other _____

Does the care receiver need assistance with eating or drinking? : ☐ Yes ☐ No

Please complete the next page.

Allergies: Food:_____ Medications:_____

Other: _____

Other restrictions or dietary concerns:_____

Vision: Eyeglasses, contacts, or vision problems:_____

Dentures or Partials:_____

Last Hospitalization date:_____Explain:

Have there been any falls: _____When?_____

Complications from falls:

Medications: (or attach a list)

List all medications and vitamins	Dose/Times	Reason/Purpose

Please complete the reverse side.

Does care receiver need help with medications? Explain:

Does care receiver have an Advance Directive or POLST (Physician's Ordered Life Sustaining Treatment)? ☐ Yes ☐ No If yes, please attach copy.

Background Information:

Occupation (former)_____

Hobbies and Interests:

Clubs/associations:

He or She loves to: ☐ read ☐ be read to. ☐ listen to radio. ☐ listen to music. ☐ watch TV.

☐ be with pets. ☐ do gardening and tend to plants. ☐ play an instrument_____

☐ play cards and games_____

☐ do crafts and skills:(sewing, woodwork, scrapbooking, collecting ,etc.) _____

_____

Anything else, like golf or sports?_____

_____

_____

What does the care receiver and caregiver (or family) enjoy doing together? What are your favorite activities at home?_____

_____

_____

How did you find out about our Adult Day Service?_____