Preferred Living Solutions

10520 Ligon Mill Rd, Ste 100-B
Wake Forest, NC 27587

919-554-0675 (Office)
919-554-2765 (Fax)

FAMILY QUESTIONNAIRE

Name_____ Date _____

Address _____City_____State_____Zip____

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

Social Security #: _____

Education _____

Religion _____ If active religiously, 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? Yes No If Yes, Carrier: _____

Medicaid # _____

List relatives, friends, and neighbors who help:

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)	

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/Diagnosis	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:

_____

_____

_____

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:					

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?

_____

_____

_____

Work and Retirement

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

How was the adjustment to retirement? Please describe.

_____

_____

Other Pertinent Information

Hospital Preference_____D.N.R. Order _____

Trust _____Lifecare _____

Will _____Living Will _____

Funeral Arrangements _____Cemetery Plot _____

Are there financial problems? Please describe._____

_____

_____

Please indicate if there is additional information you think would be helpful for us to know:

_____

_____

_____

_____

_____

_____

_____

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