

FAMILY ASSESSMENT

Elizabeth Gardens

Please take the time to **circle the areas that apply** to your relative or friend. Some of these areas concern physical status and some relate to normal behaviors for individuals with Alzheimer's/Dementia. The information you provide will help us prepare for an assessment.

Resident Name _____ Nickname _____

Sight/Vision

Normal	Right Eye	Left Eye
Partial or impaired (corrected with lenses)	Right Eye	Left Eye
Partial or impaired (not corrected with lenses)	Right Eye	Left Eye
Legally blind	Right Eye	Left Eye

Hearing

Normal-hears adequately	Right Ear	Left Ear
Uses hearing aid	Right Ear	Left Ear
Hearing impaired (can hear if spoken loudly)	Right Ear	Left Ear

Diet

Restrictions: _____

Dentures: Upper Lower

Ambulation

Normal
Ambulates with difficulty (no aids)
Ambulates with aids (walker, cane)
Wheelchair (propels self without difficulty)
Wheelchair (difficult in use)
Wheelchair (unable to use independently)

Elimination

Normal (Toilets self without assistance)
Occasional incontinence (Needs reminders but independent)
Incontinent of bowels or bladder (circle 1 or both)
Uses incontinence supplies

Bathing

Baths regularly independently
Needs reminders to bath regularly
Needs assistance with bathing
Refuses to bath regularly

Elizabeth Gardens is prepared to help those with mild behaviors that are normal for people with early onset Alzheimer's disease or dementia. Please circle any behaviors which your relative/friend exhibits.

Behavior

People are stealing things

People are coming into home and hiding things

Talking and listening to people coming into home

Feels that spouse or caregiver is an imposter

Feels that spouse is unfaithful

Does this resident:

Lose or misplace things

Repeats questions or demands

Pacing, restlessness, wandering

Wanders away from home

Constantly follows caregiver

Expresses fear of being alone

Inappropriate sexual behavior

Has persistent complaints

Hides or hoards objects

Tears up easily

Repeatedly removes clothing

wrings hands or other anxious behavior

Repetitive behavior

Behavior changes related to time of day (explain)

Reaction to Delusion

Verbal threats and accusations

Swears

Anger outbursts

Violet behaviors (slapping, biting)

Hallucinations

Sees things or people that are not there

Hears words or phrases

Person completing this form: _____

Relationship _____