Teresian House
Pre-Admission Questionnaire

Applicant's Name _________________________________ Date ___________________

In order for Teresian House to ensure that you receive the best care possible, we appreciate your answering the following questions about your daily routine and preferences. Our goal is to help you reach or maintain your optimum level of independence by answering these questions in light of your current abilities and preferences. Please complete this form and return it, prior to admission, to the attention of the Director of Admissions.

The following is a list of activities of daily living. Place a check mark in front of all items in each category that describe your abilities, and leave blank those items that do not apply to you.

1. **dressing (How do you dress yourself)**
   _____ can get my own clothing out of the closet/dresser
   _____ can put clothing on without assistance
   _____ can put shoes on without assistance
   _____ can manage buttons and zippers without assistance

   Comments ____
   ____
   ____

2. **bathing and grooming**
   _____ can get in and out of tub/shower by myself
   _____ can bathe/shower independently
   _____ need assistance washing certain areas of the body
   (please specify what areas e.g. feet, back, etc.)
   ____
   ____
   _____ can comb my hair without assistance
   _____ can brush teeth/perform denture care independently
   _____ can shave independently
   _____ can put on makeup/jewelry independently

   Comments ____
   ____
   ____

   a. Which do you prefer? _____ bath _____ shower

   b. How many times a week do you have a full bath/shower? ______________

   c. At what time do you prefer to bathe? ___________

Pre-Admission Assessment

3. Eating

______ can open containers/packages with no assistance
______ can feed myself with no assistance

______ if you eat independently but only with adaptive equipment (special utensils, dishes, placemats), place a check mark and indicate the type of adaptive equipment needed ____
____

______ can only eat "finger foods" without assistance
______ need to be totally fed by someone
______ need some help or cueing

Comments ____
____
____

4. Ambulating

______ can walk with no assistive devices (e.g. cane, walker)
______ can walk independently with: ______cane ______walker
______ can walk if someone is with me to ensure safety
______ can walk short distances (less than 50 feet):
______ without assistance ______ with assistance
______ can walk long distances:
______ without assistance ______ with assistance
______ enjoy taking regular walks:
______ without assistance ______ with assistance
______ am independent with a wheelchair
______ need to be pushed in wheelchair

Comments ____
____
____

5. Transferring

______ can get out of bed with no assistance
______ can go from the bed to a chair and vice versa, with no assistance
______ use a lift chair
______ need assistance to get out of bed or a chair
______ need total help with transfers (i.e. mechanical lift)
Comments ____
____
____

Pre-Admission Assessment

6. **Toileting**

_____ can get on and off the toilet with no assistance
_____ can get on and off the toilet independently if I have a raised toilet seat
_____ can cleanse myself with no assistance after toileting
_____ am continent, but need assistance with hygiene
_____ am incontinent, but use protective pads and can change them myself
_____ am incontinent but need assistance with incontinence products

If incontinent:

a) are you incontinent during the day, during the night, or both? __________
b) how often are you incontinent?_________________________________
c) are you incontinent of: _____urine _____ feces _____ both
d) what brand or type of incontinence product do you use?
____

Comments ____

Pain Assessment

1. Do you have any discomfort/pain? ______Location___________________________
*Please note: if answering on behalf of the prospective resident due to his/her cognitive impairment indicate nonverbal signs of pain such as behavior changes, facial expressions, change in mood that we should watch for.

Comments ____
____

2. If you have pain, indicate site(s) of pain ______________________________________

3. Is pain of such intensity that it limits your ability to perform one or more of the above daily living activities? _______yes _______no

4. Which daily activities are impacted by pain ____________________________________
____

5. When do you experience discomfort/pain? __________ Is discomfort/pain more prominent at a particular time of day? _____day _____evening _____ night

6. What do you do to alleviate the discomfort/pain? _____medication _____hot/cold packs _____topical ointments ______other______________________________________
____

7. Is the treatment you use effective? _______ To what degree: _______somewhat _______moderate relief _______total relief

8. If you do get relief from discomfort/pain, how long are you pain-free before requiring more treatment? __________________

Pre-Admission Assessment (con't)

Customary Routine

1. What time do you normally get up in the morning? _______________________

2. What time do you get dressed in the morning? __________________________

3. Do you nap during the day? _______ yes _______ no
   If yes, at what time? ____________ For how long? _________________

4. What time do you go to bed at night? _________________________________

5. Do you generally sleep through the night? _______ yes ________ no

   If no, do you: awaken to go to the bathroom? _______ yes ________ no
   (If so, how many times do you get up at night to go to the bathroom ____________)
   have trouble falling back to sleep? _______ yes ________ no
   stay awake more than 4 hours most nights? _______ yes ________ no

6. Where do you sleep at night? ____bed ____ chair ____sofa ____ other (explain)
   ____

7. In your present bedroom, is one side of your bed placed against the wall?
   ________ yes __________ no

   If yes, which side (as you are lying in the bed) is against the wall?___ left ___ right

8. What side of the bed do you get out of normally? ___left ___ right

9. Do you have someone come in during the day or night to assist with meal preparation, household chores, personal care, etc.?_______ yes _______ no

   If yes, who? ____
   which days of the week does he/she come in? _______________________
   What hours does he/she come in ?_________________________________
   With what types of things does this person assist you?
   ____
   ____

10. Which of the following do you do during a typical day? (check all that apply)
    _____ go out (shopping, visiting, etc.)
    _____ watch T.V.
    _____ read
    _____ craft work
    _____ hobbies (specify) ____
    _____ other (specify) ____

Pre-Admission Assessment (con't)

11. Do you smoke? _______ yes _______ no
If yes, how many cigarettes do you smoke per day? __________________

12. Do you drink alcoholic beverages ________ yes _______ no
If yes, how many drinks do you average? ______per day ______ per week

Medical Information

Medications	Condition for which medication is taken
________________________	____
________________________	____
________________________	____
________________________	____
________________________	____
________________________	____

Do you have any allergies to food, medications or animals? _____ yes _____no
If yes, please specify: ____
____

Do you use herbs, vitamins, rubs or any over the counter medications? ____yes ____ np
If yes, please specify. ____
Do you self administer your medications? ____ yes ____no

Surgeries: ___________________________ _________________________________
___________________________ _________________________________

Meal Patterns and Nutritional Status

1. What time do you usually eat breakfast? __________________________________

2. What do you generally eat for breakfast? _________________________________
____

3. What time do you usually eat lunch? _____________________________________

4. What time do you usually eat dinner? ____________________________________

5. Which is your most substantial meal of the day?
_____breakfast _____ lunch _____dinner

6. Do you have a good appetite? _____yes _____no

7. What is your weight? _____________

Pre-Admission Assessment (con't)

8. Have you had a recent weight change? _____ yes _____ no
If yes explain ____

9. Do you do any meal preparation? _____ yes _____ no
If no, who does? ____

10. Do you prefer to eat: _____alone? _____with others?

Activities

1. Do you actively participate in any community/church organizations? ____yes ___no
If yes, specify ____

2. Are there an activities in which you participate at least weekly? ____ yes ____ no
If yes, specify ____

3. Do you have a preference to socializing? _____yes _____ no
If so do you prefer to: (check all that apply)
_____ socializing in small groups?
_____ socializing in larger groups?
_____ pursuing solitary activities?

4. Do you spend time with a family member or friend?
_____daily _____2-3 x/week _____weekly _____monthly ____less than monthly

5. Do you belong to any particular church or synagogue? _____yes _____no

6. Do you find strength in religion? _____yes _____no

7. Do you vote in local, state and national elections? _____ yes _____no

8. Would you like to vote at Teresian House? _____yes _____no

General Questions

1. Do you enjoy your present life? _______yes _______no
If no, what would you like to change ___________________________________
____
____

2. Are you generally a happy person? _______yes _______no

3. Do things seem to bother you more lately? _______yes _______no
If yes, what things? ____
____

Pre-Admission Assessment (cont.)

4. Do you see a psychiatrist or a psychologist on a regular basis? ______yes ______no
If yes, please explain your reason for seeking counseling:
____
____

5. Do you mind having someone assist you with personal care (e.g. bathing, toileting,etc.)
____yes ____no

6. Do you ever have difficulty finding your way around?
___your house ___your neighborhood

7. Do you like animals? ______yes ______no
If yes, what kind of animals do you like? ______________________________
____

Name of Person Completing Form: ____

Relationship: ___________________________ Date: _____________________________