TERESIAN HOUSE

Where the spirit of love and dedication lives...

Personal Preferences

Applicant's Name _____ Date_____

Our goal is to help you reach or maintain your optimum level of independence. Please answer 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.

Please check 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)

☐I can get my own clothing out of the closet/dresser.
☐I can put my clothing on without assistance.
☐I can put my shoes on without assistance.
☐I can manage buttons and zippers without assistance.
Comments: _____
_____
_____

2. Bathing and grooming

☐I can get in and out of tub/shower by myself.
☐I can bathe/shower independently.
☐I need assistance washing certain areas of the body. (please specify what areas e.g. feet, back, etc.)
_____
_____
☐I can comb my hair without assistance.
☐I can brush my teeth/perform denture care independently.
☐I can shave independently.
☐I 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? _____

3. Dining

a. What time do you usually eat breakfast? _____
b. What do you generally eat for breakfast? _____
_____
c. What time do you usually eat lunch? _____
d. What time do you usually eat dinner? _____
e. Which is your most substantial meal of the day?

☐ breakfast ☐ lunch ☐dinner

f. Do you have a good appetite? ☐yes ☐no

g. Do you snack between meals? ☐yes ☐no

h. What do you prefer as a snack?
Morning Snack: _____
Afternoon Snack: _____
Evening Bedtime Snack: _____

i. Have you had a recent weight change? ☐ yes ☐ no
If yes please explain: _____

j. Do you like to cook? ☐ yes ☐ no

k. Do you prefer to eat: ☐alone? ☐ with others?

4. Walking

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

5. Transferring

☐I can get out of and into bed on my own.
☐I can go from the bed to a chair and vice versa, with no assistance.
☐I need assistance to get in and out of bed or a chair.
☐I need total assistance with transfers (i.e. mechanical lift)
Comments _____
_____

6. Toileting

☐I can toilet myself without assistance.
☐I need a raised toilet seat.
☐I can care for myself after toileting.
☐I am continent, but need assistance with hygiene.
☐I am incontinent, but use protective pads and can change them myself.
☐I am incontinent but need assistance with incontinence products.

7. Pain Assessment
   a. Do you have any discomfort/pain? _____
      *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 be aware of.
      Comments _____
      _____
   b. If you have pain, indicate site(s) of pain _____
   c. Is pain of such intensity that it limits your ability to be independent in your care?
      ☐yes ☐no
   d. When do you experience discomfort/pain? _____
   e. What do you do to alleviate the discomfort/pain? ☐medication ☐hot/cold packs ☐topical ointments
      other_____
   f. Is the treatment you use effective? _____ To what degree: _____somewhat _____moderate relief _____total relief
   g. If you do get relief from discomfort/pain, how long are you pain-free before requiring more treatment? _____

8. Daily Routine
   a. What time do you wish to get up in the morning? _____
   b. What time do you get dressed in the morning? _____
   c. Do you nap during the day? ☐ yes ☐ no
      If yes, at what time? _____ For how long? _____
   d. What time do you go to bed at night? _____
   e. Do you generally sleep through the night? _____
      If no, do you: awaken to go to the bathroom? _____
      If so, how many times do you get up at night to go to the bathroom _____
   f. Where do you sleep at night? ☐ bed ☐ chair ☐ sofa ☐ other (explain)_____
   g. 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
   h. 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? _____
      With what types of things does this person assist you?
      _____
      _____
   i. Which of the following do you do during a typical day? (please check all that apply)
      ☐ go out (shopping, visiting, etc.)
      ☐ watch T.V.
      ☐ read
      ☐ do crafts
      ☐ hobbies(please specify)_____
      ☐ other (please specify) _____
   j. Do you smoke? ☐ yes ☐ no
      If yes, how many cigarettes do you smoke per day? _____
   k. Do you enjoy a cocktail? ☐ yes ☐ no

If yes, what time of day do you enjoy your drink? _____
If yes, how often do you have a cocktail? _____per day _____ per week

9. Medical Information
   a. Do you have any allergies to food, medications? ☐ yes ☐no
      If yes, please specify:
      _____
      _____
   b. Do you take your own medications? ☐ yes ☐no
   c. Where do you keep your medications? _____
      Medicine Cabinet☐ yes ☐no
      Kitchen ☐yes ☐no
   d. When do you prefer to take your medications? _____
      With meals ☐
      Before meals ☐
      After meals ☐
   e. How often do you take your medications? _____

10. Activities
   a. Do you actively participate in any community/church organizations? ☐yes ☐no
      If yes, specify _____
   b. Are there any activities in which you participate at least weekly? ☐ yes☐ no
      If yes, specify _____
   c. Do you prefer to: (check all that apply)
      ☐socialize in small groups?
      ☐socialize in larger groups?
      ☐pursue solitary activities?
      ☐no preference?
   d. Do you belong to any particular church or synagogue? ☐yes ☐no
   e. Do you find strength in religion? ☐yes ☐no
   f. Do you vote in local, state and national elections? ☐ yes ☐no
   g. Would you like to vote at Teresian House? ☐yes ☐no

11. General Questions
   a. Do you mind having someone assist you with personal care (e.g. bathing, toileting,etc.)
      ☐yes ☐no
      b. Do you ever have difficulty finding your way around? ☐your house ☐your neighborhood
   c. Do you like animals? ☐yes ☐no
      If yes, what kind of animals do you like? _____
      _____
   d. Do you have any allergies to animals? _____

Name of Person Completing Form: _____

Relationship: _____Date: _____
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