Balance Preadmission Questionaire

Name of Person:

First _____ Middle _____ Last _____

Birthdate**:** _____ Sex**:** ☐ Female ☐ Male

Guardian/HCPOA: _____

Phone**:** _____ Cell**:** _____

Address: _____

E-Mail Address: _____

Current Living Arrangements: ☐ Family ☐ Supportive Living Arrangement ☐ Adult Family Home ☐ Relative's Home ☐ Own place/apartment ☐ CBRF

Services Requesting:

☐ Supportive Living ☐ Adult Day Program ☐ Adult Family Homes

☐ Social Skills Program (After School Children's Program)

Care Managing Organization:

☐ Care Wisconsin ☐ Community Care ☐ IRIS ☐ Other_____

CMO Case Manager: _____ **Telephone No.** _____

CMO Nurse Case Manager: _____**Telephone No.** _____

MEDICAL HISTORY: Check all those that apply.

Diagnosis: ☐ Anxiety Disorder ☐ Autism ☐ Behavioral Disorder ☐ Blind

☐ Cerebral Palsy ☐ Cardiac Disorder ☐ Deaf ☐ Developmental Disability

☐ Digestive Disorders ☐ Down Syndrome ☐ Epilepsy ☐ Fragile X Syndrome

☐ Neurological Disorder ☐ Physical Impairment ☐ Seizures

☐ Other _____

Allergies: ☐ No ☐ Yes, if yes name the allergies: _____

Diet: ☐ General ☐ Diabetic ☐ Gluten-Free ☐ Restricted Calories

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Medication: ☐ Pain Medication ☐ Anti-seizure ☐ Depression
☐ Psychotic ☐ Cardiac ☐ Diabetic ☐ Vitamins ☐ Neurological
☐ Gastrointestinal ☐ Genital/Urinal ☐ As needed (PRN)
☐ Other: _____

Primary Physician(s):

_____

Specialists Physicians:_____

Religion: ☐ Catholic ☐ Lutheran ☐ Protestant ☐ Non-denominational ☐ Atheist
☐ Hindu ☐ Muslim ☐ Jewish ☐ Do Not Wish to Disclose ☐ Other _____

Behavioral Patterns: Check all those that apply.

- ☐ Self-Injurious/Self-Abusive
- ☐ Self-stimulation
- ☐ Property Destruction
- ☐ Obsessive-Compulsive
- ☐ Sexually Inappropriate
- ☐ Combative
- ☐ Suicidal Tendencies
- ☐ Attention Seeking
- ☐ Wandering
- ☐ Non-compliant
- ☐ Verbally Aggressive
- ☐ Anxiety/Nervous

When I am happy I….

_____

When I am sad I….

_____

I feel less sad when I do….

_____

When I am angry I ….

_____

I feel less angry when I do …

_____

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When I am frustrated I ….

_____

I feel less frustrated when I do ….

_____

When I am excited I ….

_____

Other comments about feelings:

_____

Social Patterns: Check all those that apply.

Interpersonal Relationship/Communication Skills:

☐ Interacts/converses with peers/staff ☐ Needs prompting to talk ☐ Non-verbal
☐ Sign-Language ☐ Verbalizes noises ☐ Unable to follow directions ☐ Does not read
☐ Does not write

Leisure Time:

What I like to do…

☐ Television/DVD ☐ Community Outings ☐ Arts/Crafts ☐ Reading/being Read to
☐ Board Games ☐ Puzzles ☐ Word Search Books ☐ Car Rides ☐ Outdoor Activities
☐ Computer Games/Wii ☐ Family Outings ☐ Movies ☐ Religious Activity ☐ Sports
☐ Tablet/IPad ☐Other_____

What I like to do for work:

_____

What I like to do for home/life skills: ☐ Laundry ☐ Cooking/Meal Preparation ☐ Dishes
☐ Vacuum/sweep ☐ Cleaning

I really DO NOT LIKE …

_____

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It bothers me when …

_____

It is important that people know **this** about me …

_____

This is the chore I enjoy THE MOST:_____
This is the chore I enjoy the LEAST: _____

Other helpful hints. (Appropriate and easy ways to interact with me, things I may need to avoid, or other things that are helpful to know about me.)

_____

Personal Care: Check all those that apply.

Eating:

☐ Able to use utensils ☐ Finger Foods ☐ Food cut up in bite-size ☐ Mechanical Soft
☐ Puree ☐ Independent ☐ Standby with Verbal Prompts/Guidance ☐ Partial Assistance
☐ Dependent on staff ☐ Special eating utensils ☐ Choking risk/history of choking

Teeth:

☐ Own teeth ☐ Dentures ☐ Upper partial
☐ Lower partial ☐ Few teeth ☐ No teeth

Meal Preparation/Meals:

☐ Can use the stove ☐ Able to use a knife to cut up food
☐ Can use a microwave ☐ Can make a sandwich

Fluids:

☐ Cup ☐ Straws ☐ Normal ☐ Nectar Consistency ☐ Honey Consistency

GI Tube feeding:

☐ No ☐ Yes If yes: ☐ Bolus ☐ Gravity ☐ Pump

Toileting:

☐ Continent of bowel and bladder ☐ Can use the bathroom by myself
☐ Need reminders to use the bathroom ☐ Need a toileting schedule
☐ Incontinent of bladder/urine ☐ Occasionally ☐ Daytime
☐ Incontinent of bowel/BM/Stool ☐ Occasionally ☐ Daytime
☐ Wears an undergarment during the daytime ☐ Incontinent care after incontinent episodes

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Need Assistance with toileting: ☐ No ☐ Yes
☐ Need help pulling pants down ☐ Need help flushing toilet ☐ Need help washing hands
☐ Need help with hygiene after a BM
☐ Need help disposing of undergarments/change wet clothes
☐ Need help with female menses/change pad/dispose of pad
Falls: ☐ History of Falls ☐ Fall within the past month ☐ Fall within the past 3 months
☐ Fall within the past year
Mobility:
☐ Can walk up and down steps ☐ No ☐ Yes
Limitation on the distance walking: ☐ No ☐ Yes
If yes to either, please explain: _____
☐ Independent (can walk on my own) Standby Verbal Prompting/Guidance
☐ Standby/Support Assistance ☐ Gait belt ☐ Walker ☐ Wheelchair
☐ Electric wheelchair that I operate ☐ Non-ambulatory (cannot walk)
Transferring:
☐ Independently ☐ Standby Verbal Prompting/Guidance ☐ Gait belt
☐ Partial/Hands-on Assistance ☐ Sit-to-Stand Lift ☐ Hoyer Lift
Transportation:
☐ Can use public transportation/Shared Taxi ☐ Needs help with taxi passes
☐ Needs help getting in and out of vehicle ☐ Other_____

Independent Living Skills:
Education: ☐ High School ☐ College/Community College
Job: ☐ No ☐ Yes, Location/Employer: _____
☐ Job Coach ☐ Name/Phone Number: _____
Money Management:
Can count money ☐ No ☐ Yes
Can make purchases at own discretion: ☐ No ☐ Yes
Medication Management: ☐ Independently ☐ Staff needs to administer
Able to stay home alone: ☐ No ☐ Yes, If yes, how long? _____

Safety Skills: Check all those that apply
Understands Emergency Procedures regarding:
Fire: ☐ Yes ☐ No Strangers: ☐ Yes ☐ No Environment: ☐ Yes ☐ No

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Name of Person filling out this form: _____

Relationship to individual:_____

Address: _____

E-mail: _____

Date: _____

Signature of Guardian: _____

Date: _____

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Please only complete the following if interested in the Adult Family Homes:

Bathing/Shower

☐ Nightly ☐ Morning ☐ Every other day ☐ Shower chair needed ☐ Independent
☐ Standby with Verbal Prompts/Guidance ☐ Partial/Hands-on Assistance
☐ Needs help washing back ☐ Needs help washing peri area ☐ Needs help with feet/legs
☐ Needs help with arms, armpits ☐ Fully Dependent on staff

Oral Hygiene:

☐ Toothbrush ☐ Electric toothbrush ☐ Water pik ☐ Toothettes ☐ Mouthwash `
☐ Flossing ☐ Independent ☐ Standby with Verbal Prompts/Guidance
☐ Partial/Hands-on Assistance ☐ Needs help with putting on toothpaste
☐ Needs help with brushing teeth ☐ Needs help with mouthwash ☐ Needs help flossing
☐ Fully Dependent on staff

Male Shaving:

☐ AM Daily ☐ PM Daily ☐ Every other day ☐ Once a week ☐ Other _____
☐ Safety Razor ☐ Electric Razor ☐ Independent ☐ Standby with Verbal Prompts
☐ Partial/Hands-on Assistance ☐ Needs help with neck areas ☐ Needs help around the chin areas ☐ Fully Dependent on staff

Female Shaving:

☐ AM Daily ☐ PM Daily ☐Every other day ☐Once a week ☐Other _____
☐ Safety Razor ☐ Electric Razor ☐ Liquid Hair Remover ☐ Independent ☐ Standby with Verbal Prompts/Guidance ☐ Partial/Hands-on Assistance ☐ Needs help with knee areas
☐ Needs help around the ankle areas ☐ Fully Dependent on staff

Hair

☐ Cut by Family ☐ Cut by Staff ☐ Salon/Barber

Hair Washing:

☐ Independent ☐ Standby with Verbal Prompts/Guidance
☐ Partial/Hands-on Assistance ☐ Staff apply shampoo ☐ Needs help rinsing
☐ Needs help with blowing drying ☐ Dependent on staff

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Dressing

☐ Independent ☐ Picks out clothes ☐ Guidance/weather-appropriate clothing
☐ Staff Dependent/weather-appropriate clothing ☐ Standby with Verbal Prompts/Guidance
☐ Partial/Hands-on Assistance: ☐ Help with buttons/zippers
☐ Needs help with shirts/tops/bra
☐ Needs help with pants ☐ Needs help with shoes/socks ☐ Fully Dependent on staff

Medical/Recreational Appointments:

The family will make appointments ☐ No ☐ Yes, if yes FAMILY MUST LET THE HOUSE COORDINATOR KNOW WHEN AND WHERE THE APPOINTMENT IS. IF THE APPOINTMENT IS A DOCTOR'S APPOINTMENT, THE FAMILY MUST ASK FOR AN AFTER-VISIT SUMMARY AND GIVE A COPY TO THE HOUSE COORDINATOR.

AFH House Coordinator will make appointments ☐ No ☐ Yes, if yes HOUSE COORDINATOR WILL KEEP YOU UPDATED ON WHEN AND WHERE THE APPOINTMENT IS AND THE RESULTS OF THE APPOINTMENT.

Transportation to Appointments:

The family will provide transportation to appointments: ☐ No ☐ Yes, if yes, FAMILY MUST KEEP HOUSE COORDINATOR UPDATED TO WHAT TIME AND WHEN THEY WILL PICK UP THE INDIVIDUAL.
Balance will provide transportation to appointments: ☐ No ☐ Yes, if yes, HOUSE COORDINATOR WILL KEEP FAMILY UPDATED ON THE TIME AND THE DATE OF THE APPOINTMENT.

Awake/Sleep Pattern

☐ Sleeps Soundly ☐ Gets up during the night ☐ Body Pillow ☐ Half side rails ☐ Uses bathroom at night
☐ Gets a drink during the night ☐ Uses a C-pap at night
Generally goes to bed in PM at: _____Gets up in AM at: _____

Name of Person filling out this form: _____

Relationship to individual:_____

Address: _____

E-mail: _____

Date: _____

Signature of Guardian: _____

Date: _____

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