

**The Maples
Pre-Admission Questionnaire**

Applicant's Name _____ Date _____

In order for The Maples 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 Admissions Coordinator.

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 such as 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? _____

3. **Eating**

- _____ can open containers/ packages with no assistance
- _____ can feed myself with no assistance
- _____ can eat independently but only with adaptive equipment (special utensils, dishes, placements)
- _____ 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 device (such as a 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 distance: _____without assistance _____with assistance
- _____ enjoy taking regular walks: _____without assistance _____with assistance
- _____ 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 (for example mechanical lift)

Comments _____

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? _____

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? _____
If so, is discomfort/pain more prominent at a particular time of day? ___day ___night
6. What do you do to alleviate the discomfort/pain? ___medication ___hot/cold packs
___topical ointments ___other such as _____
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 treatment?

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? _____)
Do you have trouble falling back to sleep? ___yes ___no
Do you stay awake more than 4 hours most nights? ___yes ___no
6. Where do you sleep at night? ___bed ___chair ___sofa ___other such as _____

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 TV

_____ read

_____ craft work

_____ hobbies (specify) _____

_____ other (specify) _____

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 take:

Do you have any allergies to food, medications or animals? ___yes ___no

If yes, please specify: _____

Do you use herbs, vitamins, rubs or over the counter medications? ___yes ___no

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? _____

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 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 times a week weekly monthly less than monthly

5. Do you belong to any particular church or synagogues? yes no

6. Do you find strength in religion? yes no

7. Do you vote in local, state and notional elections? yes no

8. Would you like absentee ballots provided to vote at The Maples? 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? _____

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 (bathing, toileting, etc)

yes no

6. Do you ever have difficulty finding your way around your house? yes no

7. Do you ever have difficulty finding your way around your neighborhood? yes no

8. Do you like animals? yes no

If yes, what kind of animals do you like? _____

Name of person completing form: _____

Relationship: _____ Date: _____