

# Client Information Profile

DNR Yes  No   
Documentation on file? Yes  No

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_  
Marital Status: Single Married Divorced Widowed  
Spouses Name: \_\_\_\_\_  
Client Lives Alone? Yes  No   
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

## Contact Information

	Primary Contact	Secondary Contact	Other Contact
Name:	_____	_____	_____
Relationship:	_____	_____	_____
Phone Work:	_____	_____	_____
Phone Home:	_____	_____	_____
Phone Cell:	_____	_____	_____

## Family, Friends, etc:

<u>Name</u>	<u>Relationship</u>	<u>Phone Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Clergy/Rabbi \_\_\_\_\_ Phone \_\_\_\_\_

## Biography

Birthday \_\_\_\_\_ Place of Birth \_\_\_\_\_ Languages Spoken  English  
Previous Cities or Towns of Residence \_\_\_\_\_  French  
Schools or Universities Attended \_\_\_\_\_  Other  
Occupations \_\_\_\_\_  
Pets \_\_\_\_\_  
Interests \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Health Provider Contact Information

### Primary Physician

Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_  
Other Information \_\_\_\_\_

### Other Physicians/Healthcare providers

Dentist	_____	Address	_____	Phone	_____
Pharmacist	_____	Address	_____	Phone	_____
Optometrist	_____	Address	_____	Phone	_____
Optician	_____	Address	_____	Phone	_____
Podiatrist	_____	Address	_____	Phone	_____
Chiropractor	_____	Address	_____	Phone	_____
Other	_____	Address	_____	Phone	_____
Other	_____	Address	_____	Phone	_____
Other	_____	Address	_____	Phone	_____

### Miscellaneous Contact Information

Service	_____	Contact	_____	Phone	_____
Service	_____	Contact	_____	Phone	_____
Service	_____	Contact	_____	Phone	_____

### Healthcare Insurance/Private Coverage Information

Provincial Healthcare Number \_\_\_\_\_  
Private Healthcare Plan Name \_\_\_\_\_ Private Plan Number \_\_\_\_\_  
Supplemental Health Insurance Plan  
Company \_\_\_\_\_ Plan Coverage \_\_\_\_\_ Policy Number \_\_\_\_\_  
Company \_\_\_\_\_ Plan Coverage \_\_\_\_\_ Policy Number \_\_\_\_\_  
Other Health Insurance Coverage (eg DVA) \_\_\_\_\_ Policy Number \_\_\_\_\_

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# Leisure Profile

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LEISURE	HOBBIES	SPORTS	OTHER
<input type="checkbox"/> Birds <input type="checkbox"/> Board Games <input type="checkbox"/> Bridge <input type="checkbox"/> Cards <input type="checkbox"/> Cats <input type="checkbox"/> Crosswords <input type="checkbox"/> Dogs <input type="checkbox"/> History <input type="checkbox"/> Horses <input type="checkbox"/> Internet <input type="checkbox"/> Movies <input type="checkbox"/> Museums <input type="checkbox"/> Music <input type="checkbox"/> Newspaper <input type="checkbox"/> Painting <input type="checkbox"/> Poetry <input type="checkbox"/> Politics <input type="checkbox"/> Radio <input type="checkbox"/> Reading <input type="checkbox"/> Resting <input type="checkbox"/> Shopping <input type="checkbox"/> Television <input type="checkbox"/> Tropical Fish <input type="checkbox"/> Walking	<input type="checkbox"/> Antiques <input type="checkbox"/> Archaeology <input type="checkbox"/> Astronomy <input type="checkbox"/> Art <input type="checkbox"/> Camping <input type="checkbox"/> Coins <input type="checkbox"/> Collectables <input type="checkbox"/> Cooking <input type="checkbox"/> Dolls <input type="checkbox"/> Gardening <input type="checkbox"/> Ham Radio <input type="checkbox"/> Metal Working <input type="checkbox"/> Model Building <input type="checkbox"/> Nature <input type="checkbox"/> Puzzles <input type="checkbox"/> Rock Hound <input type="checkbox"/> Stamps <input type="checkbox"/> Trains <input type="checkbox"/> Travel <input type="checkbox"/> Woodworking  <input type="checkbox"/> Musical Instruments <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Baseball <input type="checkbox"/> Basketball <input type="checkbox"/> Boating <input type="checkbox"/> Bowling <input type="checkbox"/> Canoeing <input type="checkbox"/> Cross Country Skiing <input type="checkbox"/> Curling <input type="checkbox"/> Darts <input type="checkbox"/> Diving <input type="checkbox"/> Downhill Skiing <input type="checkbox"/> Fishing <input type="checkbox"/> Formula 1 Racing <input type="checkbox"/> Golf <input type="checkbox"/> Hockey <input type="checkbox"/> Lawn Bowling <input type="checkbox"/> Nascar Racing <input type="checkbox"/> Rodeo <input type="checkbox"/> Sailing <input type="checkbox"/> Scuba Diving <input type="checkbox"/> Swimming <input type="checkbox"/> Tennis <input type="checkbox"/> Volleyball <input type="checkbox"/> _____ <input type="checkbox"/> _____	<p>Places Traveled</p> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____  <p>Other Interests</p> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

## Behavior Profile

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✓	BEHAVIOR	NOTES
	Addiction - Alcohol	
	Addition - Drugs	
	Aggressive - Physically	
	Aggressive - Verbally	
	Agitated	
	Apathetic	
	Cognitive Problems	
	Confused	
	Demanding	
	Depression	
	Disorder - Paranoid	
	Disorder - Schizophrenic	
	Eating Disorder	
	Extraverted/Introverted	
	Forgetful	
	Frail	
	Hallucinations	
	Hearing - Deaf	
	Hearing - Impaired	
	Illiterate	
	Incontinent	
	Insomnia	
	Kleptomaniac	
	Lonely	
	Mentally Challenged	
	Obsessive Compulsive	
	Pain	
	Seizures	
	Sexual Expression	
	Speech - Impediment	
	Speech - Mute	
	Suicidal	
	Violent	
	Vision - Blind	
	Vision - Impaired	
	Wanders	

## Home Services Profile

<p><input type="checkbox"/> <b>Light Housekeeping</b> Notes: _____ _____ _____</p> <p><input type="checkbox"/> <b>Laundry</b> Notes: _____ _____ _____</p> <p><input type="checkbox"/> <b>Meal Preparation</b> Notes: _____ _____ _____</p> <p><input type="checkbox"/> <b>Outdoor Maintenance</b> Notes: _____ _____ _____</p>	<p><input type="checkbox"/> <b>Dusting</b> <input type="checkbox"/> Vacuum <input type="checkbox"/> Damp Mop <input type="checkbox"/> Change Bedding <input type="checkbox"/> Bathroom <input type="checkbox"/> General Tidying <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Wash <input type="checkbox"/> Dry <input type="checkbox"/> Iron <input type="checkbox"/> Fold <input type="checkbox"/> Put Away</p> <p><input type="checkbox"/> Meal Planning <input type="checkbox"/> Preparation <input type="checkbox"/> Cooking <input type="checkbox"/> Serving <input type="checkbox"/> Wash Dishes <input type="checkbox"/> _____ <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Gardening <input type="checkbox"/> Lawn <input type="checkbox"/> Snow <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____</p>	<p><input type="checkbox"/> <b>Pet Care</b> Notes: _____ _____</p> <p><input type="checkbox"/> Dog _____ <input type="checkbox"/> Cat _____ <input type="checkbox"/> Fish _____ <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> <b>Personal Care</b> Notes: _____ _____ _____ _____ _____ _____ _____</p> <p><input type="checkbox"/> Medicine Reminder <input type="checkbox"/> Dressing <input type="checkbox"/> Bathing <input type="checkbox"/> Hairdressing <input type="checkbox"/> Makeup <input type="checkbox"/> Washing <input type="checkbox"/> Shaving <input type="checkbox"/> Nail Care <input type="checkbox"/> _____ <input type="checkbox"/> _____</p> <p><input type="checkbox"/> <b>Attendant</b> Notes: _____ _____ _____</p> <p><input type="checkbox"/> Shopping <input type="checkbox"/> Appointments <input type="checkbox"/> Church <input type="checkbox"/> Friends <input type="checkbox"/> Activities</p>	<p><b>Other:</b> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____</p> <p><b>Notes:</b> _____ _____ _____ _____</p>
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**Housekeeping Notes:**

- Living Room \_\_\_\_\_
- Dining Room \_\_\_\_\_
- Kitchen \_\_\_\_\_
- Family Room \_\_\_\_\_
- Master Bed \_\_\_\_\_
- Ensuite \_\_\_\_\_
- Bedroom 1 \_\_\_\_\_
- Bedroom 2 \_\_\_\_\_
- Bedroom 3 \_\_\_\_\_
- Bathroom 1 \_\_\_\_\_
- Bathroom 2 \_\_\_\_\_
- Bathroom 3 \_\_\_\_\_
- Basement \_\_\_\_\_
- Other \_\_\_\_\_

## Dietary Profile

Food Allergies Yes  No       Peanuts  Shellfish  Dairy produce  Eggs  Other \_\_\_\_\_

Previous response \_\_\_\_\_      Actions required \_\_\_\_\_

Help with feeding required: Self  Assist  Total

<b>BREAKFAST</b> Usual Time:	<b>LUNCH</b> Usual Time:	<b>SUPPER</b> Usual Time:	<b>SNACKS</b> Usual Times:
<p><b>Notes:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Notes:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Notes:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Notes:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Favorite Foods</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Favorite Foods</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Favorite Foods</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Favorite Foods</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Dislikes</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Dislikes</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Dislikes</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Dislikes</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

### Daily Routine

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
6am	_____	_____	_____	_____	_____	_____	_____
7am	_____	_____	_____	_____	_____	_____	_____
8am	_____	_____	_____	_____	_____	_____	_____
9am	_____	_____	_____	_____	_____	_____	_____
10am	_____	_____	_____	_____	_____	_____	_____
11am	_____	_____	_____	_____	_____	_____	_____
Noon	Noon_____	Noon_____	Noon_____	Noon_____	Noon_____	Noon_____	Noon_____
1pm	_____	_____	_____	_____	_____	_____	_____
2pm	_____	_____	_____	_____	_____	_____	_____
3pm	_____	_____	_____	_____	_____	_____	_____
4pm	_____	_____	_____	_____	_____	_____	_____
5pm	_____	_____	_____	_____	_____	_____	_____
6pm	6pm_____	6pm_____	6pm_____	6pm_____	6pm_____	6pm_____	6pm_____
7pm	_____	_____	_____	_____	_____	_____	_____
8pm	_____	_____	_____	_____	_____	_____	_____
9pm	_____	_____	_____	_____	_____	_____	_____
10pm	_____	_____	_____	_____	_____	_____	_____
11pm	_____	_____	_____	_____	_____	_____	_____

### Monthly Routine

	WEEK 1	WEEK 2	WEEK 3	WEEK 4	DAY	ACTIVITY
M	_____	M	_____	M	_____	_____
T	_____	T	_____	T	_____	_____
W	_____	W	_____	W	_____	_____
T	_____	T	_____	T	_____	_____
F	_____	F	_____	F	_____	_____
S	_____	S	_____	S	_____	_____
S	_____	S	_____	S	_____	_____