



# Tuscaloosa County Sheriff's Office Project Lifesaver Alabama



## Personal Data Questionnaire

This form is designed for *Custodial Care Givers* to provide, in advance, certain information that will be useful to Search Teams, should the need arise. Providing the information in advance of the need will allow Search Management Personnel to do their job faster, when needed.

Resident: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**Date Transmitter Placed:** \_\_\_\_\_

Facility/Organization: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Person filling out this form: \_\_\_\_\_

### Resident's Personal Data

Birthdate: \_\_\_\_\_ Sex: M / F Race: \_\_\_\_\_

Nickname(s): \_\_\_\_\_

Most Recent Address: \_\_\_\_\_

Most Recent Place of Work: \_\_\_\_\_

Most Recent Occupation: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Living / Deceased (circle)

### Family/Friend Information

Other persons the resident may contact (family, friends, etc.)

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

Phone: \_\_\_\_\_

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

Phone: \_\_\_\_\_

**Physical Description**

Height \_\_\_\_\_ ft, \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. Build \_\_\_\_\_

Hair Color: \_\_\_\_\_ Hair Style: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Complexion: \_\_\_\_\_ Beard: Yes / No Sideburns Yes / No (circle one)

Mustache Yes / No Balding Yes / No False Teeth Yes / No (circle one on each)

Shape of facial features: Round / Square / Oval / Other \_\_\_\_\_

Distinguishing Marks, Scars, Tattoos. Etc. Describe: \_\_\_\_\_

General Appearance: \_\_\_\_\_

If Resident does not understand English, what Language is understood? \_\_\_\_\_

Spoken word only Yes / No (circle one) or Written / Spoken (circle one)

Does Resident Wear Glasses? Yes / No Contacts? Yes / No Sunglasses? Yes / No

If yes to any of the above, what style? \_\_\_\_\_

If Resident wears glasses or corrective eyewear what degree of vision does he/she have without the eyewear? None / Poor / Fair (circle one)

**Personal Data Questionnaire**

Does Resident wear a Hearing Aid? \_\_\_\_\_ What Style? \_\_\_\_\_

If yes, What type of Hearing without Aid? None / Poor / Fair (circle one)

**Health/Psychological Condition**

Any known physical handicaps? \_\_\_\_\_  
(Describe please)

Any know Medical Problems? \_\_\_\_\_  
(Describe Please)

Medications taken regularly? \_\_\_\_\_

List any medications using correct name of drug and dosage taken: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Consequences of NOT taking medications? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Attending Physician: \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_

Any Psychological Problems? Yes / No Nature: \_\_\_\_\_

\_\_\_\_\_

**If Alzheimer's Disease has been diagnosed, Answer the following:**

1. Does the Resident remain oriented to Time and Person? Yes / No  
Explain: \_\_\_\_\_
2. Does the Resident recognize familiar persons and faces? Yes / No  
Explain: \_\_\_\_\_
3. Can the Resident travel to familiar locations? Yes / No  
Explain: \_\_\_\_\_
4. Does the Resident have decreased knowledge of current events or tend to re-live events in his/her life? Yes / No  
Explain: \_\_\_\_\_
5. Does the Resident sometimes cloth themselves improperly? Yes / No  
Example: Putting shoes on wrong feet or adding underwear over clothing?  
Explain: \_\_\_\_\_
6. Does the Resident remember their own name and names of spouse and or children? Yes / No  
Explain: \_\_\_\_\_
7. Are the Resident's sleep patterns frequent? Yes / No  
Explain: \_\_\_\_\_
8. Does the Resident suffer from frequent personality and emotional changes? Yes / No  
Explain: \_\_\_\_\_
9. Does the Resident suffer from delusions (See imaginary visitors, talk to his/her own reflection in the mirror, Imagine that their spouse is an imposter, etc) Yes / No