Freighter View Assisted Living Community

Pre-Screening Questionnaire

Current Living Situation

Check all that apply.

I presently live:

_____In my own home/apartment
_____Senior Community
_____With Spouse
_____Alone
_____With family members
_____With friends

Assistance Needed

Check all that apply. If you are unsure, make the best estimated guess.

Area of Assistance	Yes	No	Type of Assistance
Bathing	_____	_____	_____Preparation/Set-up _____Assist to/from Shower _____Stand-by assist for steadying _____Light Washing _____Significant Washing
Ambulation	_____	_____	_____Prosthesis _____Cane _____Walker _____Wheelchair _____Occasional Monitoring _____Stand by assist for safety _____Moderate ambulation assistance to meals and events _____Significant ambulation and transfer assistance
Grooming	_____	_____	_____Prompting/Reminding _____Set-up _____Moderate Assistance _____Significant Assistance

Area of Assistance	Yes	No	Type of Assistance
Dressing	_____	_____	_____Prompting _____Occasional physical assist with zippers, shoes, stockings, etc. _____Moderate regular assistance with putting clothes on/off _____Full regular assistance
AM/PM Preparation	_____	_____	_____Prompting/Reminding _____Awaken in AM _____Assist out of bed _____Daily checks _____Assist into bed _____Frequent checks through day _____Overnight checks _____Total care/All wake up and bedtime tasks are assisted with
Toileting	_____	_____	_____Occasional prompting _____Regular prompting _____Assist on/off toilet _____Stand by assist for safety _____Maintain toileting schedule _____Light assistance in changing undergarments (undressing/cleaning) _____Full assistance _____Assistance with stoma/catheter
Orientation	_____	_____	_____Light/occasional orientation _____Regular orientation and/or intervention/supervision due to moderate impairment _____Frequent orientation and/or intervention/supervision due to significant impairment
Special Diet	_____	_____	_____Diabetic _____ Low Sodium _____Low fat _____Vegetarian _____Mechanical Soft _____Pureed

Area of Assistance	Yes	No	Type of Assistance
Dining	______	______	_____Special utensils _____Light assistance (Opening cartons, wrappers, cutting meat, etc.) _____Supervised dining/special placement _____Full assistance
Medication	______	______	_____1 to 4 Medications _____5 to 9 Medications _____10 or more Medications _____Light management/reminders _____Significant management _____Full assist with ordering/set up/administering
Health Promotion (monthly)	______	______	_____Regular monitoring of vitals _____Frequent monitoring of vitals/health condition (weekly) _____Daily monitoring of vitals _____Stable health condition which requires occasional intervention and monitoring _____Stable health condition which requires consistent intervention and monitoring _____Light assistance in health maintenance and planning (scheduling appointments, corresponding with physician, advising resident)
Housekeeping/Laundry	______	______	_____Twice weekly housekeeping assistance and laundry service _____Light daily assistance (bed making, cleaning, laundry) _____Moderate daily assistance; may have occasional moderate accidents _____Significant daily housekeeping, cleaning or laundering; may have regular/heavy accidents