Caregiver Form 2010a

I. Profile

I.A. Caregiver Identification

1. What is the date of the assessment?

_____/_____/_____

2. Specify the type of assessment, or the reason for the assessment.

- ☐ Initial assessment
- ☐ Reassessment

3. What is the name of the person conducting this assessment?

_____

4. What is the name of the agency the assessor works for?

_____

5. What is the client's first name?

_____

6. What is the client's last name?

_____

7. What is the client's middle initial?

_____

8. Enter the client's residential street address or Post Office box.

_____

9. Enter the client's residential city or town.

_____

10. Enter the client's state of residence.

_____

11. Enter the client's residential zip code.

_____

12. Enter the client's mailing street address or Post Office box.

_____

13. Enter the client's mailing city or town.

_____

14. Enter the client's mailing state.

_____

15. Enter the client's mailing ZIP code.

_____

16. What is the client's social security number (SSN)?

_____-_____-_____

17. Enter the primary local client identifier for the client.

_____

18. Enter the client's telephone number.

_____

19. Alternate telephone number for client

_____

20. What is the client's gender?

- ☐ Female
- ☐ Male

21. What is the client's date of birth?

_____/_____/_____

22. Enter the age of the client in years.

☐

23. Select the client's current marital status.

- ☐ Divorced
- ☐ Legally Separated
- ☐ Married
- ☐ Single
- ☐ Widowed

24. What is the client's primary caregiver's ethnicity?

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

25. What is the client's race?

- ☐ American Indian/Native Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Missing
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Non-Minority (White, non-Hispanic)
- ☐ Other
- ☐ White-Hispanic

26. Is the client currently employed?

- ☐ Full time
- ☐ Part time
- ☐ No

I.B. Caregiver Profile

1. What is the care recipient's last name?

_____

2. What is the care recipient's first name?

_____

3. Does the client live with the care recipient?

- ☐ No
- ☐ Sometimes
- ☐ Yes

4. What is the relationship of the client to the care recipient?

- ☐ Daughter/Daughter-in-law
- ☐ Grandparent (60+)
- ☐ Husband
- ☐ Non-relative
- ☐ Other elderly non-relative (55+)
- ☐ Other elderly relative
- ☐ Other relative
- ☐ Relationship Missing
- ☐ Son/Son-in law
- ☐ Wife

5. What is the care recipient's status.

- ☐ Alzheimer's disease or related disorder
- ☐ Client elderly (60+)
- ☐ Disabled (18 to 59)
- ☐ Minor (18 and under)

6. How long has client provided most of the care?

- ☐ Less than 6 months
- ☐ 6 to 12 months
- ☐ 1 to 2 years
- ☐ 2 to 5 years
- ☐ 5+ years

7. Does the client have any other caregiving responsibilities? (Children, other adults, etc.)

_____

_____

_____

_____

8. Describe any significant changes or events that have taken place in the client's life during the last six months.

_____

_____

_____

_____

9. Are there other persons who can assist the client with the care recipient if the client is not available?

- ☐ No
- ☐ Yes

10. What contacts/services/supportive interventions have been provided for the client?

_____

_____

_____

_____

11. Do others assist the client with the care recipient?

- ☐ No
- ☐ Yes

II. Caregiving Tasks

II.A. Type of Service

1. Does the primary client provide the care recipient with personal care?

- [ ] Yes
- [ ] No

2. Does the client help the care recipient with housekeeping?

- [ ] Yes
- [ ] No

3. Does the client help the care recipient manage his/her money?

- [ ] Yes
- [ ] No

4. Does the client help the care recipient with shopping and/or errands?

- [ ] Yes
- [ ] No

5. Does the client help the care recipient with taking medication?

- [ ] Yes
- [ ] No

6. Does the client provide the care recipient with transportation?

- [ ] Yes
- [ ] No

7. Does the client provide the care recipient with other assistance?

- [ ] Yes
- [ ] No

8. If services were not in place, would there be anything that would make it difficult for the client to provide care?

- [ ] Yes
- [ ] No

9. How often does the care recipient receive assistance from the client?

- [ ] Monthly
- [ ] Weekly
- [ ] One to two times per week
- [ ] Three or more times per week
- [ ] Once daily
- [ ] Several times during day
- [ ] Several times during day and night

III. Impact of Caregiving

III.A. Caregiver Challenges

1. How does the client rate his/her health?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

2. Does the client feel that s/he has lost control of his/her life since the care recipient became ill?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

3. Does the client feel that his/her health has suffered because of involvement with the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

4. Does the client feel that the care recipient affects his/her relationship with family members/friends in a negative way?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

5. Does the client feel that his/her social life has suffered because s/he is caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

6. Does the client feel that s/he doesn't have enough privacy because of caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

7. Does the client feel that s/he does not have enough time for him/herself because of the time spent caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

8. Does the client feel stressed between caring for the care recipient and trying to meet other responsibilities?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

9. Does the client feel angry when s/he is around the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

10. Does the client feel that s/he does not have enough money to take care of the care recipient and pay for the rest of his/her expenses?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

11. Overall, does the client feel burdened caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

12. Indicate the behaviors the care recipient has demonstrated at least one a week.

- ☐ Delusional
- ☐ Disruptive behavior
- ☐ Getting lost/wandering
- ☐ Impaired decision-making
- ☐ Memory deficit
- ☐ Physical aggression
- ☐ Verbal disruption
- ☐ Not applicable

Title : _____ Date

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