Baycrest
Enriching Care
Enhancing Knowledge
Enlightening Minds

Questionnaire for Family Members and/or Caregivers

Thank you for agreeing to fill out the following questionnaire. This document should be filled out by you, to the best of your ability; NOT by a healthcare professional. Your answers to these questions will help guide our assessment. Please do not worry if you forget something or do not know all the answers. Please note the time you start and finish the questionnaire.

We will do our best to address your questions and concerns during our scheduled appointment. Thank you.

PART I

Please list ALL the medications and supplements your family member takes regularly, including the doses if you know them:

2. Do they have any allergies? Yes____ No____

If yes, please list the substance and the reaction**:**

3. Has your family member ever smoked? Yes____ No____

a. If yes, how many packs per day, for how many years: ……

4. Did they ever drink alcohol? Yes____ No____

If yes:

a. Do they still drink alcohol? Yes____ No____

b. what do /did they drink? (wine, beer, liquor): ……..

c. how much do / did they drink? ……..

d. do they drink more than they used to? Yes____ No____

e. if they no longer drink when did they stop, and why?

……

……

5. Has your family member ever used recreational drugs (like marijuana)?

Yes____ No____

PART II

1. Has there been a change in your family member's ability to do their day-today activities and tasks? Yes____ No____

If yes, has it been:

a. a gradual decline over months or years Yes____ No____

b. a gradual decline with a recent SUDDEN change Yes____ No____

c. stable with a recent SUDDEN change Yes ____ No____

2. Does your family member need help with any of the following tasks?
(DO NOT include things they choose not to do or never did)

a. Managing money/bills Yes ____ No ____

b. Taking medications Yes____ No ____

c. Transportation/driving Yes ____ No ____

d. Preparing meals Yes ____ No____

e. Cleaning the house Yes ____ No ____

f. Using the telephone and/or computer Yes ____ No ____

3. Does your family member need help with any of the following tasks?

a. Bathing? Yes ____ No ____

b. Dressing/grooming? Yes____ No ____

c. Using the toilet? Yes____ No ____

d. Feeding themselves? Yes ____ No ____

e. Going up/down stairs? Yes ____ No____

4. Does your family member use a cane or a walker? Yes____ No ____

5. Who helps your family member at home? ……..

6. Does your family member have any of the following in their home?

a. Grab bars in the bathroom Yes____ No____

b. Raised toilet seat Yes ____ No ____

c. Bath chair Yes ____ No____

7. Are you or others experiencing stress with the amount of care your family member needs? Yes ____ No ____

8. Has your family member assigned Power of Attorney for Personal Care in case he/she can no longer make decisions for him or herself?

Yes____ No____

a. If so, to whom? ……..

9. Has your family member assigned Power of Attorney for Property, in case he/she can no longer make financial decisions? Yes____ No____

a. If so, to whom? ……..

Part III:

1. Has your family member:

a. Left the stove on accidentally? Yes____ No ____

b. Left the tap on accidentally? Yes____ No ____

c. Ever gotten lost? Yes____ No____

2. Does your family member have problems with thinking or memory?

Yes____ No____

a. If yes, when did you first notice these problems?

……

……

3. Do you think your family member is depressed or has problems with their nerves? Yes ____ No____

4. Does your family member nap during the day? Yes____ No____

5. How many times has your family member fallen in the last year?

0____ 1-2 ____ 3-4____ 4-5____ more than 6____

6. Does your family member have problems with vision? Yes ___ No____

a. Do they wear glasses? Yes____ No____

b. When was the last time they had their eyes assessed?

< 1year____ >1 year____

7. Does your family member have problems with hearing?

a. Have they ever been assessed for hearing aids? Yes____ No____

8. Does your family member leak urine? Yes____ No ____

9. Does your family member have problems with their bowels:

a. constipation Yes____ No ____

b. diarrhea Yes____ No ____

c. soiling / incontinence Yes____ No____

10. Does your family member wear incontinence products (eg. Depends)

Yes___ No____

11. Has your family member lost weight recently? Yes____ No____

a. Was this on purpose? Yes____ No____

12. Does your family member have trouble swallowing? Yes___ No____

13. Does your family member have any skin problems? Yes___ No ____

14. Does your family member report pain? Yes___ No____

a) Where? ……

……

PART IV

1. Does anyone in the family have any of the following?

a. Dementia: Yes____ No____ Who? ……

b. Parkinson's disease: Yes____ No____ Who? ……..

c. Cancer: Yes____ No____ Who? ……..

c. Depression/mental health problems: Yes___ No____ Who? ……..

d. Substance Use: Yes____ No____ Who?……..

PART V

How long did it take you to fill out this questionnaire? ……

Thank you!