1. Do you now have, or have you ever had a problem with alcohol? YES NO

EXPLAIN _____

_____

_____

2. Have you ever been hospitalized for alcoholism or related illness? YES NO

EXPLAIN (WHERE/WHEN) _____

_____

_____

3. Do you now have or have you ever had a problem with illicit drugs (marijuana, cocaine, etc)? YES NO

EXPLAIN _____

_____

_____

4. Has applicant ever been treated for a psychiatric (mental) illness? YES NO

EXPLAIN (Diagnosis, Where, When) _____

_____

_____

5. Is applicant currently participating in any experimental research therapy program? YES NO

EXPLAIN/DESCRIBE _____

_____

_____

ADDITIONAL COMMENTS: (Describe daily routine, personality, habits, likes/dislikes, etc)

_____

_____

_____

_____

NAME -_____ _____

SIGNATURE

RELATIONSHIP TO APPLICANT:_____

DATE:_____ Please return this form with your application. FALSIFICATION OF INFORMATION MAY RESULT IN THE APPLICANT BEING DENIED ADMISSION OR DISCHARGED FROM THE NURSING HOME.

VSO 106 (OF Version Mar 99)

APPLICANT ACTIVITIES OF DAILY LIVING SURVEY FORM

(This Survey Form is needed by the Admission Screening Committee to more accurately evaluate the amount and type of care needed by the applicant. PLEASE CIRCLE THE APPROPRIATE ANSWER FOR EACH ITEM. Incomplete and/or unsigned forms will delay processing of the application.)

BEHAVIORS:

Alert/Aware	YES	NO
Hostile Physically (Fights)	YES	NO
Yells	YES	NO
Wanders	YES	NO
Comatose (Unconscious)	YES	NO
Cooperative	YES	NO

WALKING:

Walks by Self	YES	NO
Uses cane or walker	YES	NO
Uses Wheelchair	YES	NO
Stays in Bed or Chair	YES	NO
Falls Frequently	YES	NO

MOVEMENT FROM BED TO CHAIR/TOILET:

Moves by Self	YES	NO
Has to be carried or helped	YES	NO
Shifts weight in chair by Self	YES	NO
Turns Self in Bed	YES	NO
Able to Use Nurse Call Button	YES	NO

EXERCISE OF LIMBS:

Moves arms by self	YES	NO
Moves legs by self	YES	NO
Receives Physical Therapy	YES	NO

DRESSING:

Dresses upper body by self	YES	NO
Dresses lower body by self	YES	NO
Puts on socks and shoes by self	YES	NO
Receives Occupational Therapy	YES	NO

BATHING:

Needs Bed Bath Given	YES	NO
Takes Tub Bath by self	YES	NO
Takes Shower by self	YES	NO
Resists Bathing	YES	NO

EATING:

Feeds self	YES	NO
Feeding Tube	YES	NO
Eats complete meal	YES	NO

Diet Type (Specify): _____

GROOMING:

Shaves self	YES	NO
Brushes own teeth/dentures	YES	NO
Trims own nails	YES	NO

TOILETING:

Bowel Control	YES	NO
Bladder Control	YES	NO
Urinary Catheter (Tube in Bladder)	YES	NO
Colostomy (Hole in Abdomen)	YES	NO
Illeostomy (Tube in Bladder)	YES	NO

SKIN CONDITION:

Dry Skin	YES	NO
Bruises easily	YES	NO
Skin tears easily	YES	NO
Rash on body	YES	NO
Bedsores	YES	NO

How Many: _____

Where: _____

_____

BREATHING STATUS:

Uses Oxygen Tanks/concentrator	YES	NO
Tracheostomy (hole in throat)	YES	NO
Needs suctioning	YES	NO
Can cough	YES	NO
Smokes Tobacco	YES	NO

OTHER:

Poor vision	YES	NO
Blind	YES	NO
Wears glasses/contacts	YES	NO
Deaf	YES	NO
Wears Hearing aid	YES	NO
Can talk/communicate	YES	NO
Needs safety devices	YES	NO
Dentures	YES	NO
Artificial limbs or braces	YES	NO
Legal Guardian	YES	NO
Power of Attorney (POA)	YES	NO
Living Will	YES	NO
Durable Power of Attorney for Healthcare	YES	NO