

**LIONS PROJECT LIFE SAVER  
OTTAWA COUNTY**

**Client Data Questionnaire**

Client Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_

**CLIENT PHYSICAL DESCRIPTION**

DOB: \_\_\_\_\_ Sex: M F Race: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Build: \_\_\_\_\_  
Hair Color: \_\_\_\_\_ Hair Style: \_\_\_\_\_ Eye Color: \_\_\_\_\_  
Complexion: \_\_\_\_\_ Facial Hair: \_\_\_\_\_  
Scars, Marks, Tattoos: \_\_\_\_\_

Glasses: Y N If yes, are they worn full-time? Y N  
Hearing Aids? Y N  
Is the client's primary language English: Y N If no, what language? \_\_\_\_\_

**MEDICAL/PYCHOLOGICAL INFORMATION**

Client's Physician: \_\_\_\_\_  
Address & Phone: \_\_\_\_\_  
Does the client have any known medical problems? Y N  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the client have any psychological problems? Y N  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List the medications taken by the client: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY/FRIEND CAREGIVER INFORMATION**

Name of Spouse: \_\_\_\_\_ Living / Deceased

Does the spouse reside with the client? Y N If no, where? \_\_\_\_\_

Name of any former Spouse(s): \_\_\_\_\_ Living / Deceased

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

Primary caregiver: \_\_\_\_\_

Address and phone if different from client: \_\_\_\_\_

**If the Client lives in a managed care facility:**

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

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

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

List other persons (friends, family) the client may contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

**OTHER CLIENT INFORMATION**

Client's communication skills: None Poor Fair Good Excellent

List articles normally carried by the client: \_\_\_\_\_

Former addresses where the client lived: \_\_\_\_\_

Is the client familiar with the area? Y N How recent (months/years): \_\_\_\_\_

If no, what area(s) are known/familiar to the client? \_\_\_\_\_

Does the client use: Cane Walker Other, please specify below:  
\_\_\_\_\_  
\_\_\_\_\_

Has the client ever walked away or been lost before? Y N  
If yes, when and where? \_\_\_\_\_  
Location found: \_\_\_\_\_  
Actions taken: \_\_\_\_\_

**PERSONALITY / HABITS**

Does the client smoke? Y N How often? \_\_\_\_\_  
Does the client use alcohol? Y N How often/type? \_\_\_\_\_  
Does the client use illicit drugs? Y N What type? \_\_\_\_\_  
Does the client have fears (dogs, cats, people, noises, darkness, etc.)? \_\_\_\_\_  
\_\_\_\_\_

Will the client talk to strangers? Y N  
Is the client a danger to self or others? Y N If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

List the client's hobbies / interests: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of person assisting to complete this form: \_\_\_\_\_  
Name of interviewer: \_\_\_\_\_

*The below section is to be completed by Search & Rescue / Project Lifesaver Specialist...*

Date installed: _____	Photo attached: Yes No
Frequency: _____	Deviation: _____
Location where received was / will be attached: _____	
Was the caregiver(s) given an explanation as to how Project Lifesaver works and the requirements for testing the transmitter daily? Yes No	
Caregiver's name _____	
Caregiver's signature _____	
Search & Rescue member name: _____ ID # _____ Date: _____	

Attach photo below: