**Falls Township Police Department**
188 Lincoln Highway
Fairless Hills, Pa 19030
215-949-9100

**Care Trak Northeast**
PO Box 225
Lyndonville, VT 05851
802-467-3496

# RAPID RECOVERY PROGRAM
# PERSONAL DATA QUESTIONNAIRE

This form is designed for Custodial Care Givers to provide, in advance, certain information that will be useful to search teams, should the need arise. Providing the information in advance of the need will allow search management personnel to do their job faster, when needed. Please include 2 photos with this questionnaire.

Clients Name _____ Nick Name _____

Address _____

City/State/Zip _____

## Care Giver

Care Giver _____ Phone No. _____

Facility Name _____ Phone No. _____

Address _____

City/State/Zip _____

## Personal Data

Date of Birth _____ Sex ☐Male ☐ Female Race ☐White ☐Black ☐Asian ☐Indian

Height _____ Weight _____ Hair _____ Eyes _____ Build _____ Complexion _____

Beard _____ Mustache _____ Glasses _____ Contacts _____ Missing/False Teeth _____

Style of glasses/frame color _____ Without glasses, how is vision? ☐None ☐Poor ☐Fair

Hearing Aid? _____ Without hearing aid, how is client's hearing ☐ None ☐ Poor ☐ Fair

Scars/Marks/Tattoos _____

Most Recent Address _____

Most Recent Occupation _____ Where? _____

Name of Spouse _____ ☐ Living ☐ Deceased

Does the client speak any other language? ☐ Yes ☐ No What Language? _____

Does the client read/write? ☐ Yes ☐ No Correspond with anyone? _____

Is client dangerous to him/herself or others? _____

Will client talk to strangers? _____

How well does the client communicate? ☐ None ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Physical Handicaps _____

Psychological Problems _____

Medical Problems _____

Medications _____

Consequences if not taken? _____

Physician _____ Phone No. _____

| | | | |
|---|---|---|---|
| **Client Name** | | **Frequency Number** | |
| **GPS** | | **Date** | |

## Other Family/Friends in area

Name _____ Phone No. _____

Address _____

Name _____ Phone No. _____

Address _____

## Personal Articles Normally Carried by the Client

Tobacco _____ Type/brand _____ Lighter/matches _____ Candy/gum _____

Food _____ Handbag/purse _____ Jewelry/Watch _____ Cane/Walker _____

## Is client afraid of

Dogs _____ Noises _____ People _____ the dark _____ Other _____

## Answer the following if Alzheimer's has been diagnosed ☐ Yes ☐ No

Does client remain oriented to person, place time? _____

explain: _____

Does client recognize familiar people or faces? _____

Can the client travel to familiar places on their own? _____

Does the client have decreased knowledge of current events or tend to re-live events? _____

Does the client sometimes clothe his/herself improperly? _____

Does the client remember his/her own name, spouse, children? _____

explain _____

Does the client have frequent sleep patterns? _____

Does the client suffer from frequent personality and emotional changes? _____

explain _____

Does the client suffer from delusions (audible or visual)? _____

explain _____

RAPID RECOVERY