



**PRINCE WILLIAM COUNTY  
OFFICE OF THE SHERIFF**

9311 Lee Avenue

Manassas, Virginia 20110



Glendell Hill  
Sheriff

## Personal Data Questionnaire

DO NOT WRITE- OFFICIAL USE ONLY

Client Number: \_\_\_\_\_ Frequency: \_\_\_\_\_ Team Member Initials: \_\_\_\_\_

This form is designed for Custodial Care Givers to provide, in advance, certain information that will be useful to Project Lifesaver team members and, should the need arise, searchers. Providing the information in advance of the need will give team members the necessary information to provide a more effective response.

Client Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City/State: \_\_\_\_\_ ZIP: \_\_\_\_\_

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

Caregiver Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City/State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### **Client/Caregiver Preliminary Questions:**

Date: \_\_\_\_\_

1. Does the client presently operate a motor vehicle? Yes/No (circle)
2. Does the client have a history of aggressive or violent behavior? Yes/No

3. Are you as the caregiver willing to abide by the requirements of the program? Yes/No
4. Are "temporary caregivers" outside the home, willing to abide by the program requirements? Y/N
5. Will the client be willing to wear the transmitter on wrist or ankle at all times? Yes/No
6. Is the client continually supervised, twenty-four hours a day, seven days a week? Yes/No
7. Does the client attend school or other supervised care program outside the home? Yes/No

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**Date Transmitter Placed:**

\_\_\_\_\_

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

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

Name of Person filling out this form: \_\_\_\_\_

**Client's Personal Data**

Birthdate: \_\_\_\_\_ Mental Capacity Age: \_\_\_\_\_ Sex: Male/Female (circle) Race: \_\_\_\_\_

Nickname(s): \_\_\_\_\_

Most recent address: \_\_\_\_\_

Most recent place of employment: \_\_\_\_\_

Most recent occupation: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Living/deceased (circle)

**Family/Friend Information**  
**Other persons the client may contact (family, friends, etc.)**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**Client Physical Description**

Height: \_\_\_\_\_ ft., \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs. Build: \_\_\_\_\_

Hair Color: \_\_\_\_\_ Hair Style: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Complexion: \_\_\_\_\_ Beard Yes/No (circle) Sideburns Yes/No (circle)

Mustache Yes/No (circle) Balding Yes/No (circle) False Teeth Yes/No (circle)

Shape of Facial Features: Round/Square/Oval/Other: \_\_\_\_\_

Distinguishing Marks, Scars, Tattoos, etc. (describe): \_\_\_\_\_

General Appearance: \_\_\_\_\_

Is the Client able to communicate? Circle all that apply: Speak/Write/Sign/Mute/Deaf/Other?

Explain: \_\_\_\_\_

Client's level of communication comprehension: \_\_\_\_\_

If Client does not understand English, what language is understood? \_\_\_\_\_

Is the Client able to read? Yes/No (circle) Reading Level: \_\_\_\_\_

Does the Client wear Glasses? Yes/No (circle) Contacts? Yes/No (circle) Sunglasses? Yes/No (circle)

If yes to any of the above, what style? \_\_\_\_\_

What degree of vision does the Client have without eyewear? None/Poor/Fair/Good (circle)

Does the Client wear a Hearing Aid? Yes/No (circle) If so, what style? \_\_\_\_\_

What degree of hearing does the Client have without an Aid? None/Poor/Fair/Good (circle)

**Health/Psychological Condition**

List all Physical Handicaps:

Physical Handicap 1: \_\_\_\_\_

Explanation of Physical Handicap 1: \_\_\_\_\_

Physical Handicap 2: \_\_\_\_\_

Explanation of Physical Handicap 2: \_\_\_\_\_

List all Medical Handicaps:

Medical Handicap 1: \_\_\_\_\_

Explanation of Medical Handicap 1: \_\_\_\_\_

Medical Handicap 2: \_\_\_\_\_

Explanation of Medical Handicap 2: \_\_\_\_\_

Medical Handicap 3: \_\_\_\_\_

Explanation of Medical Handicap 3: \_\_\_\_\_

List all Medications:

Drug 1: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason: \_\_\_\_\_

Consequences of **NOT** taking this medication: \_\_\_\_\_

Drug 2: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason: \_\_\_\_\_

Consequences of **NOT** taking this medication: \_\_\_\_\_

Drug 3: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason: \_\_\_\_\_

Consequences of **NOT** taking this medication: \_\_\_\_\_

Attending Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

List all Psychological Handicaps:

Psychological Handicap 1: \_\_\_\_\_

Explanation of Psychological Handicap  
1: \_\_\_\_\_

Psychological Handicap 2: \_\_\_\_\_

Explanation of C Handicap 2: \_\_\_\_\_

Psychological Handicap 3: \_\_\_\_\_

Explanation of Psychological Handicap 3: \_\_\_\_\_

Does Client have any mobility problems? Yes/No (circle) If Yes, what problems: \_\_\_\_\_

\_\_\_\_\_

**If Alzheimer's disease has been diagnosed, answer the following:**

Does the Client remain oriented to Time and Person? Yes/No (circle)

Explain: \_\_\_\_\_

Does the Client recognize familiar persons and faces? Yes/No (circle)

Explain: \_\_\_\_\_

Can the Client travel to familiar locations? Yes/No (circle)

Explain: \_\_\_\_\_

Does the Client have decreased knowledge of current events or tend to re-live past events? Yes/No (circle)

Explain: \_\_\_\_\_

Does the Client sometimes dress improperly? Yes/No (circle)

Explain: \_\_\_\_\_

Does the Client remember his/her own name and the names of spouse and/or children? Yes/No (circle)

Explain: \_\_\_\_\_

Are the Client's sleep patterns frequently altered? Yes/No (circle)

Explain: \_\_\_\_\_

Does the Client suffer from frequent personality and emotional changes? Yes/No (circle)

Explain: \_\_\_\_\_

Does the Client suffer from delusions (See imaginary visitors, talk to her/her own reflections in the mirror, imagine that their spouse is an imposter, etc)? Yes/No (circle)

Explain: \_\_\_\_\_

How good is the Client's communication ability? None/Poor/Fair/Good/Excellent (circle)

Personal Articles Normally Carried by the Client:

Tobacco Products: Yes/No (circle) Type: \_\_\_\_\_ Brand: \_\_\_\_\_

Candy/Gum: Yes/No (circle) Brand: \_\_\_\_\_

Matches: Yes/No (circle) Lighter: Yes/No (circle) Type: \_\_\_\_\_

Food Items: \_\_\_\_\_

Facial tissue or other pocket/purse items: \_\_\_\_\_

\_\_\_\_\_

Approximate amount of Cash on hand? \$ \_\_\_\_\_

Where normally carried: \_\_\_\_\_

Handbag, Purse or Wallet (describe): \_\_\_\_\_

Jewelry (describe): \_\_\_\_\_

Watch (describe): \_\_\_\_\_

Cane/Walker: Yes/No (circle) Describe: \_\_\_\_\_

Hunting/Fishing equipment: \_\_\_\_\_

Other: \_\_\_\_\_

### **Experience**

Is the Client familiar with the area? Yes/No (circle) Length of residence? \_\_\_\_\_

If not local, what other areas are known to the Client? \_\_\_\_\_

\_\_\_\_\_

Has Client taken outdoor classes? Yes/No (circle) Explain: \_\_\_\_\_

Has Client taken First Aid training? Yes/No (circle) Explain: \_\_\_\_\_

Was Client involved in Scouting? Yes/No (circle) Explain: \_\_\_\_\_

Does Client have Military experience? Yes/No (circle) Explain: \_\_\_\_\_

Recreational outdoor experience? Yes/No (circle) Explain: \_\_\_\_\_

Overnight Camping experience? Yes/No (circle) Explain: \_\_\_\_\_

Ever been lost before? Yes/No (circle) Where/When: \_\_\_\_\_

Was Client found or walked out on own? \_\_\_\_\_

Location found: \_\_\_\_\_

Actions taken: \_\_\_\_\_

Does Client ever go out alone? Yes/No (circle) Explain: \_\_\_\_\_

Does Client stay on trails? Yes/No (circle) Explain: \_\_\_\_\_

General athletic interest/abilities: \_\_\_\_\_

### **Personality/Habits**

Does the Client drink Alcohol? Yes/No (circle) Explain: \_\_\_\_\_

Does the Client use Illicit Drugs? Yes/No (circle) Explain: \_\_\_\_\_

Hobbies/Interests: \_\_\_\_\_

Does the Client swim or participate in water based activities? Yes/No (circle) Explain: \_\_\_\_\_

Is Client Outgoing or Reserved (likes groups or being alone)? Outgoing/Reserved/Neither Extreme (circle)

Does the Client show evidence of Leadership? Yes/No (circle) Explain: \_\_\_\_\_

\_\_\_\_\_

Has the Client ever been in trouble with the law? Yes/No (circle) Explain: \_\_\_\_\_

\_\_\_\_\_

Is the Client Religious? Yes/No (circle) Explain: \_\_\_\_\_

What Faith? \_\_\_\_\_

What physical items does the Client value most? \_\_\_\_\_

Which Family Member is the Client closest to? \_\_\_\_\_

What is the nature of their relationship (relative, friend)? \_\_\_\_\_

Where was the Client born and raised? \_\_\_\_\_

Has the Client received a letter recently? Yes/No (circle) From whom: \_\_\_\_\_

Is the Client afraid of: dogs, the dark, noises, horses, people, other? (circle)

If Other, describe: \_\_\_\_\_

What action does the Client take when hurt? Cry, shout, remain silent, other. (circle)

If Other, describe: \_\_\_\_\_

Will the Client talk to strangers? Yes/No (circle) Will the client approach strangers? Yes/No (circle)

Does the Client have access to a vehicle? Yes/No (circle) If so, please describe it completely: \_\_\_\_\_

Is the Client **DANGEROUS** to themselves or others? Yes/No (circle) Themselves/Others (circle)

Explain: \_\_\_\_\_

What other information do you feel needs to be shared concerning the Client? \_\_\_\_\_

**School Information**

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

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

Hours: \_\_\_\_\_

How is the client transported to and from school? \_\_\_\_\_