STAMFORD POLICE DEPARTMENT PROJECT LIFESAVER

Personal Data Questionnaire

This form is designed for 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 jobs more efficiently, when needed.

Resident: _____

Address: _____

City/State: _____ Zip: _____

Phone: _____

Date Transmitter Placed: _____

Facility/Organization: _____ Phone: _____

Name of Pearson Filling Out This Form: _____

Resident's Personal Data

Birthdate: _____ Sex: Male / Female Race: _____

Nickname(s): _____

Most Recent Address: _____

Most Recent Place of Work: _____

Most Recent Occupation: _____

Name of Spouse: _____ Living / Deceased (circle one)

Family / Friend Information

Other persons the resident may contact (family, friends, etc.)

Name: _____ Address: _____

Phone: _____ _____

Name: _____ Address: _____

Phone: _____ _____

Name: _____ Address: _____

Phone: _____ _____

Physical Description

Height: _____ Weights:_____ Build: _____
Hair Color: _____ Hair Style: _____
Complexion: _____ Facial Hair: _____

Eye Color: _____ False Teeth: Yes / No (circle one)

Distinguishing Marks/Scars/Tattoos:

Shape of Facial Features : Round / Square / Oval / Other _____

General Appearance: _____

If Resident does not understand English, what language is understood?:_____
Spoken word only: Yes / No or Written / Spoken: Yes / No

Does Resident Wear Glasses?: Yes / No Contacts?: Yes / NO Sunglasses?: Yes / No
If yes to any of the above, what style?: _____
If Resident wears corrective eyewear, what degree of vision does he/she have without the eyewear?:
None / Poor / Fair (circle one)

Does Resident wear a hearing aid?:_____ What style?: _____
If yes, what type of hearing does he/she have without the hearing aid? None / Poor / Fair (circle one)

Heath / Mental Heath Information

Any known physical handicaps? (Describe) _____
Any known medical problems? (Describe) _____
Medications taken regularly? _____
Consequences of NOT taking medications? _____
Attending Physician: _____ Phone: _____
Any Mental Health Problems? Yes / No Nature: _____

Check One: [ ] Alzheimer's [ ] Developmental [] Brain Injury [ ] Dementia

1. Does the Resident remain oriented to time and person? Yes / No
   Explain:_____

2. Does the Resident recognize familiar persons and faces? Yes / No
   Explain:_____

3. Can the Resident travel to familiar locations? Yes / No
   Explain:_____

4. Does the Resident have decreased knowledge of current evens or tend to re-live evens in his/her life? Yes / No

5. Does the Resident sometimes clothe himself/herself improperly? Yes / No (Example: Putting shoes on the wrong feet, adding underwear over clothing?)
   Explain: _____

6. Does the Resident remember his/her own name and the names of spouse and/or children? Yes / No
   Explain:_____

7. Are the Resident's sleep patterns irregular? Yes / No
   Explain:_____

8. Does the Resident suffer from frequent personality and emotional changes? Yes / No
   Explain:_____

9. Does the Resident suffer from delusions (see imaginary visitors, talk to his/her own reflection in the mirror, imagine that his/her spouse is an imposter, etc.)? Yes / No
   Explain: _____

10. How good is the Resident's communication ability?: None / Poor / Fair / Good / Excellent

Personal articles normally carried by Resident:

Tobacco Products: Yes / No Type: _____ Brand: _____
Matches: Yes / No Lighter: Yes / No Brand: _____
Candy/Gum: Yes / No Brand:_____

Food Items: _____
Facial tissue or other pocket, purse items: _____

Equipment:

Cane / Walker: Yes / No Other:_____
Hunting or Fishing, etc.: _____
Other: _____

Experience

Familiar with area? Yes / No How recently _____ days / months / years (circle one)

If not local, what other areas are know to the Resident?: _____

_____

Taken outdoor classes? Yes / No Where? _____ When?: _____

Taken first aid training? Yes / No Where? _____ When? _____

Involved in Scouting? Yes / No Explain _____

Military experience Yes / No Where?_____ When? _____

Recreational outdoor experience? Yes / No _____

Overnight camping experience? Yes / No _____

Ever been lost before? Yes / No Where? _____ When? _____

Located by Searchers or walked out by his/herself? _____

Location found _____ Action taken _____

Personality / Habits

Smoke? Yes / No How Often? _____ What: _____ Brand:_____
Drink alcohol? Yes / No Type: _____ Brand:_____
Use illicit Drugs? Yes / No How Often? _____ Brand:_____
Hobbies/Interests:_____
_____
General athletic interest/abilities: _____
_____

Ever goes out alone? Yes / No Stays on trails? Yes / No

General demeanor: Outgoing / Quiet Prefers: Groups / Being Alone
Evidence of leadership? Yes / No
Explain: _____
Approximate amount of cash on hand? $_____
Where normally carried:
Handbag / Purse / Wallet / Pocket Other:_____
Description (Type, Color, etc.): _____

Jewelry (Please describe): _____
Watch? Yes / No Type:_____ Color: _____ Description: _____
_____

Ever been in trouble with the law? Yes / No For What:_____

Religious? Yes / No What Faith?: _____

What does Resident value most?: _____
Which family member is Resident closet to? _____ Relationship: _____
Where was Resident born and raised? _____
Has Resident received any letter/package recently? Yes / No From whom:_____
Is Resident afraid of (circle all that apply): Dogs? The Dark? Noises? Horses? People?
Other:_____
What actions taken when hurt? (cry, shout, etc.): _____
Will Resident talk to strangers? Yes / No
Is the Resident DANGEROUS to himself/herself or others? Yes / No

STAMFORD POLICE DEPARTMENT

PROJECT LIFESAVER

INFORMATION SHEET

IF YOUR LOVED ONE WANDERS, QUICKLY SEARCH THE HOUSE. SPEND NO MORE THAN 5 MINUTES LOOKING.

THEN CALL OUR 24 HOUR COMMUNICATION CENTER:

203-977-4444

TELL THEM HE/SHE IS A PROJECT LIVESAVER CLIENT

HOW LONG AGO YOU SAW THEM AND WHAT THEY WERE WEARING.