CAREGIVER HEALTH ASSESSMENT

For adults with developmental disabilities (DD)

This health information helps the caregiver to know more about the person with a developmental disability and their health problems. This information can also be helpful to the family physician or other primary care providers.

This health information is **private** to this person and their care providers. **PLEASE – KEEP IT CONFIDENTIAL.**

- Include the person with DD in the process of completing the form as fully as possible. Get further health care information from family members, other caregivers and available medical records.
- Fill it out as completely as possible – it is okay to check "Don't Know".
- The form can be used at Intake and at team meetings. It should be updated when changes occur.

Name: ___________________________________ Gender: _____
(last, first)
Address: ___________________________________

City, Province: ____________________ Postal Code: __________

Tel. No: ___________________________________

Date of birth (dd/mm/yyyy): ___________________________

Likes to be called: ___________________________________

Assessment completed: ___________________________
(dd/mm/yyyy)

by: ____
(name) (role) (title)

____
(name) (role) (title)

ALLERGIES

Allergies

List any known allergies to *medicines, food, and/or things in the environment*, and what happens if exposed:

Allergic to: ______________________ What happens: ______________________

Allergic to: ______________________ What happens: ______________________

Allergic to: ______________________ What happens: ______________________

NB: If the person with DD has a significant medical condition (e.g., diabetes, epilepsy, asthma or allergies), a Medic-Alert device is recommended

BACKGROUND INFORMATION

Background information

Cause of DD if known: ___________________________________ ☐ **Unknown**

Ever had a genetic assessment? ☐ No ☐ Unsure ☐ Yes → Year: __________ Copy on file? ☐ No ☐Yes

Comments:

Ever had a psychological assessment? ☐ No ☐ Unsure ☐ Yes → Year: __________ Copy on file? ☐ No ☐Yes

Comments:

Has this person been diagnosed with an Autism Spectrum Disorder? ☐ No ☐ Yes

CONTACT INFORMATION

Contact information

CONTACT	NAME and ADDRESS	PHONE NUMBERS and/or EMAIL (Home, Work, Cell)
Primary decision maker for health-related matters, if the person with DD is unable to consent: ☐ Substitute Decision Maker ☐ Power of Attorney for Personal Care		
Next of Kin – Relationship: ______________________		
Other family members/Significant Others – Relationship: ______________________		
Agency involved:		

© 2013 Surrey Place Centre

FAMILY HISTORY

Family history

Has anyone in this person's family (mother, father, brothers, sisters or other relatives) **had any of the following conditions? If yes,** *specify the relative(s) who had it (e.g., mother, brother).*

DEVELOPMENTAL DISABILITY	☐ Yes ______________ (relationship) (type of DD) ☐ Yes ______________ (relationship) (type of DD)	☐ Don't know
CARDIOVASCULAR DISEASE (e.g., heart disease, high blood pressure)	☐ Yes ______________	☐ Don't know
OSTEOPOROSIS	☐ Yes ______________	☐ Don't know
SEIZURES/EPILEPSY	☐ Yes ______________	☐ Don't know
MENTAL ILLNESS (e.g., depression, anxiety, Schizophrenia)	☐ Yes ______________ (relationship) (type of illness) ☐ Yes ______________ (relationship) (type of illness)	☐ Don't know
DIABETES	☐ Yes ______________	☐ Don't know
CANCER	☐ Yes ______________ (relationship) (type of cancer) ☐ Yes ______________ (relationship) (type of cancer) ☐ Yes ______________ (relationship) (type of cancer)	☐ Don't know
OTHER ILLNESSES	☐ Yes ______________	☐ Don't know

If parent(s) have died, how old were they when they died and what did they die from?

MOTHER: Age at death: _____ years; Cause: ______________ ☐ Don't know

FATHER: Age at death: _____ years; Cause: ______________ ☐ Don't know

PERSONAL HISTORY

Personal history

Living Situation: ☐ Family ☐ Group home ☐ Foster home ☐ Independent ☐ Other:__________________

Most important relationships:

Caregivers and supports:

Employment or Day Program (indicate total hours/week):

Leisure Activities:

Exercise (what type and how often):

Complementary/alternative treatments and/or supplements:

RISKS

Risks

TOBACCO	# of cigarettes/ day =	# of years:
CAFFEINE	# of ____________________/day =	
ALCOHOL	# of drinks/week	
STREET DRUGS	# of ___________________/week =	
BEHAVIOUR	Describe:	

© 2013 Surrey Place Centre

HEAD TO TOE REVIEW

If you are unsure of the answer, please check "Don't Know" rather than guessing.
If not applicable, do not check anything.

Height (cm) _______________ Weight (kg) _______________ BMI = height/weight or cm/kg ________________

1. EYES, EARS, NOSE/MOUTH/THROAT, TEETH: **Does this person…**		**NO**	**DON'T KNOW**	**YES**	**If YES, CHANGE in past year?**
Eyes	• Wear **glasses**?	☐	☐	☐	☐
	• Have any **problems with vision**?	☐	☐	☐	☐
	• Ever have **redness or drainage** from eyes?	☐	☐	☐	☐
	• **Squint or rubbing** eyes?	☐	☐	☐	☐
	• Other: ____	☐	☐	☐	☐
	Last Eye Doctor Appointment: ______________________________ (dd/mm/yyyy)				
	Results: ____				
Ears	• Wear a **hearing aid**?	☐	☐	☐	☐
	• Have any signs of **hearing problems**?	☐	☐	☐	☐
	• Ever have **earwax** problems?	☐	☐	☐	☐
	• Have signs of ear problems (e.g., ear infections, drainage from ears)? *If yes*, how often? ____	☐	☐	☐	☐
	Last Hearing Test Appointment: ____________________________ (dd/mm/yyyy)				
	Results: ____				
Nose/ Mouth/ Throat	• Ever have sinus infections? *If yes*, how often? ____________________	☐	☐	☐	☐
	• Ever have a sore throat? *If yes,* how often? ______________________	☐	☐	☐	☐
	• Have sores in the mouth?	☐	☐	☐	☐
	• Have bad breath?	☐	☐	☐	☐
	• Have a **dry mouth**?	☐	☐	☐	☐
	• Have **excess saliva**?	☐	☐	☐	☐
	• Have problems with **chewing**?	☐	☐	☐	☐
	• Have problems with **swallowing** (e.g., chokes, gags or coughs during or after eating or drinking)?	☐	☐	☐	☐
Teeth	• Have **own teeth**?	☐	☐	☐	☐
	• Have **false teeth** or **partial dentures**?	☐	☐	☐	☐
	• Have **no teeth and no dentures**?	☐	☐	☐	☐
	• Have problems with teeth?	☐	☐	☐	☐
	• **Toothaches**?	☐	☐	☐	☐
	• **Gum problems** (e.g., swollen gums or bleeding when brushing)?	☐	☐	☐	☐
	• Have **poor oral hygiene** (brushing or flossing <2x/day)?	☐	☐	☐	☐
	• Have **poor denture hygiene**?	☐	☐	☐	☐
	• Refuse to go or hasn't been to the **dentist in more than 1 year**?	☐	☐	☐	☐
	• Need **sedation** for dental procedures? *If yes,* how has it been arranged? ______________________________	☐	☐	☐	☐
	Last Dental Appointment: ______________________________ (dd/mm/yyyy)				
	Results: ____				

© 2013 Surrey Place Centre

2. HEART and CIRCULATION OF BLOOD: Does this person…	NO	DON'T KNOW	YES	If YES, CHANGE in past year?
Heart and Circulation				
• Have **high blood pressure** (hypertension)?	☐	☐	☐	☐
If yes, does the person take **medications** for high blood pressure?	☐	☐	☐	☐
• Have **heart disease**?	☐	☐	☐	☐
If yes, what **kind** of heart problem/test results? ______________________	☐	☐	☐	☐
• Ever have problems with **heart "racing"** or **missing beats**?	☐	☐	☐	☐
• Ever complain of **pain** in chest, left arm or jaw?	☐	☐	☐	☐
• Ever complain of **pain** in calves with walking?	☐	☐	☐	☐
• Have **swelling** of the feet or ankles?	☐	☐	☐	☐
• Get **short of breath** when lying in bed or walking up a flight of stairs?	☐	☐	☐	☐
• Ever get **blue skin** (e.g., fingernails, lips, toes)?	☐	☐	☐	☐
• **Other:** ______________________				
3. LUNGS and BREATHING: Does this person… [1] *If yes*, consider using a ***Sleep Chart***				
Lungs and Breathing				
• Have **asthma**?	☐	☐	☐	☐
• Have **COPD** (chronic obstructive pulmonary disease or emphysema)?	☐	☐	☐	☐
If yes, are they on **medications**, e.g., puffers?	☐	☐	☐	☐
If yes, is the person's asthma or COPD well **controlled**? (e.g., no emergency department visits in the last year)	☐	☐	☐	☐
• Get frequent **colds**?	☐	☐	☐	☐
• Get frequent **pneumonia**?	☐	☐	☐	☐
• Get frequent **bronchitis**?	☐	☐	☐	☐
• Have a **cough** that doesn't go away?	☐	☐	☐	☐
• Have **shortness of breath** or **wheezing**?	☐	☐	☐	☐
• Cough up **mucous**? *If yes*, describe: ______________________	☐	☐	☐	☐
• Cough up **blood**? *If yes*, describe: ______________________	☐	☐	☐	☐
• Have **sleep apnea**?	☐	☐	☐[1]	☐
If yes: (please circle) **diagnosed** or **suspected**				
If yes, do they use a device? (please circle) **No device/CPAP/BiPAP**				
• **Other:** ______________________				
4. STOMACH AND BOWEL: Does this person… [2] *If yes*, consider using a ***Weight Chart*** [3] *If yes*, consider using a ***Bowel Movement Chart***				
Stomach				
• Have a **special diet**? *If yes, specify:* ______________________	☐	☐	☐	☐
• Have problems with **eating**?	☐	☐	☐	☐
• **Have** other **stomach or feeding problems?**______________________	☐	☐	☐[2]	☐
• **Vomit** or **regurgitate**?	☐	☐	☐	☐
• Have **heartburn**?	☐	☐	☐	☐
• Have **pain or discomfort after eating**?	☐	☐	☐	☐
• Have a ☐ **weight gain** or ☐ **weight loss** (more than 5 kg in past year)? *If yes*, ☐ intentional ☐ unexplained	☐	☐	☐[2]	☐
• Have **poor nutrition** – *how?* ______________________	☐	☐	☐	☐
• **Eat** ☐ **too much** or ☐ **too little**	☐	☐	☐	☐
• **Drink** ☐ **too much** or ☐ **too little**	☐	☐	☐	☐
• **Have unbalanced diet** (e.g., overly selective, …)?	☐	☐	☐	☐
• Have **PICA** (eats non-food material, e.g., paper, dirt)?	☐	☐	☐	☐

© 2013 Surrey Place Centre

4. STOMACH AND BOWEL: Does this person…	NO	DON'T KNOW	YES	If YES, CHANGE in past year?
Stomach				
• Have a **feeding tube**? – *If yes:*	☐	☐	☐	☐
• Does the person ever cough, gag or choke during or after feeds?	☐	☐	☐	☐
• Is it also used for medications?	☐	☐	☐	☐
• Any problems with it? ___	☐	☐	☐	☐
• What type of feeding tube? ___ What feed is used? ___				
• When was it put in? ___ Where was it put in? ___				
• How often is it changed? ___ Who changes it? ___				
Bowel				
• Have **problems with his or her bowels**?	☐	☐	☐[3]	☐
• **Constipation** (stools less than every two days or hard/difficult/painful to pass) – *how often?* ___	☐	☐	☐[3]	☐
• **Diarrhea or watery stool** – *how often?* ___	☐	☐	☐	☐
• **Black bowel movements** or **blood in stools?** – *how often?* ___	☐	☐	☐	☐
• **Loses control** of bowels, has "accidents"? – *how often?* ___	☐	☐	☐	☐
• **Needs adult incontinent briefs** for bowels?	☐	☐	☐	☐
• If any bowel problems, is a **bowel protocol** in place?	☐	☐	☐	☐
• **Other**: ___				
5. BLADDER and GENITALS: Does this person have…				
Bladder and Genitals				
• Frequent **bladder or kidney infections**?	☐	☐	☐	☐
• Problems with passing urine?				
• Pass urine a lot or ☐ **more** or ☐ **less** than usual?	☐	☐	☐	☐
• Bed wetting? ☐ **new** or ☐ **longstanding**?	☐	☐	☐	☐
• **Loss of control** passing urine or incontinence?	☐	☐	☐	☐
• **Pain or difficulty** when passing urine?	☐	☐	☐	☐
• **Blood** in the urine?	☐	☐	☐	☐
• Urine that has an **unusual colour** or **bad odour**?	☐	☐	☐	☐
• A **catheter**? ☐ **permanent** or ☐ **intermittent**	☐	☐	☐	☐
• **Other**: ___				
6. A. SEXUAL FUNCTION: Is this person…				
Sexual Function				
• **Ever sexually active**, now or in the past?	☐	☐	☐	☐
• *If active*, does person use **contraceptives**? *If yes*, name type (e.g., condoms, DepoProvera, oral contraceptive pills): ___	☐	☐	☐	☐
• *If active*, do they use **Sexually Transmitted Infection (STI) prevention practices**? *If yes*, name type (e.g., condom): ___	☐	☐	☐	☐
• Any known current or past **STIs**? *If yes*, specify: ___	☐	☐	☐	☐
• Doing any sexually **inappropriate behaviours** (e.g., touching, etc.)?	☐	☐	☐	☐
• Does this person have any **masturbation issues**? *If yes,* check below: ☐ public ☐ private ☐ tissue damage ☐ interferes with daily life	☐	☐	☐	☐
• **Other**: ___				

© 2013 Surrey Place Centre

6. B. WOMEN'S HEALTH: Does this person… [4] *If yes*, consider **Menses Chart**	NO	DON'T KNOW	YES	If YES, CHANGE in past year?
• **Menses** (women's period)? ☐ Regular ☐ Irregular ☐ Controlled with Medication	☐	☐	☐	☐
• Have any **physical discomfort** associated with her menstrual periods?	☐	☐	☐[4]	☐
• Have any **behavioural changes** related to her menstrual cycle?	☐	☐	☐[4]	☐
• Have problems managing her periods (e.g., cleanliness)?	☐	☐	☐[4]	☐
• Have any **unusual vaginal bleeding or discharge**?	☐	☐	☐[4]	☐
• Has she been **pregnant**?	☐	☐	☐	☐
If yes, how many times? ___________				
If yes, how many live births? ____ Years born ____________________				
• Have **menopausal symptoms?** (e.g., hot flashes) Describe: ______________________________	☐	☐	☐	☐
• Has she ever had a Pap smear? If yes, most recent: (yyyy)____________	☐	☐	☐	☐
• Has she ever had a mammogram? If yes, most recent: (yyyy)__________	☐	☐	☐	☐

Women's Health

6. C. MEN'S HEALTH: Does this person…	NO	DON'T KNOW	YES	If YES, CHANGE in past year?
• Have **difficulty starting to pass urine**?	☐	☐	☐	☐
• Have any **blood** or **unusual discharge** from his penis?	☐	☐	☐	☐
• Have any **sores** on his penis?	☐	☐	☐	☐
• Have any **lumps** in his groin or **pain** in his groin?	☐	☐	☐	☐
• Is this person able to achieve and maintain an **erection**?	☐	☐	☐	☐
• Most recent **men's health screening**:				
Testicular exam (yyyy): ______________				
Prostate exam (yyyy): ______________				

Men's Health

7. MUSCLES, JOINTS and MOBILITY: Does this person… (focus on any change in mobility/walking) *If yes, consider keeping a pain record*	NO	DON'T KNOW	YES	If YES, CHANGE in past year?
• Have **joint pain**?	☐	☐	☐	☐
• Have **joint swelling**?	☐	☐	☐	☐
• Have **back pain**?	☐	☐	☐	☐
• Have **muscle pain** or **stiffness**? (Circle as it applies)	☐	☐	☐	☐
If yes, location: ______________________________				
• Have a **history of broken bones**? *If yes*:	☐	☐	☐	☐
Location: ______________ (dd/mm/yyyy) ____________				
Location: ______________ (dd/mm/yyyy) ____________				
• Have a diagnosis of **osteoporosis** (brittle bones)?	☐	☐	☐	☐
If yes, date of diagnosis (dd/mm/yyyy) ____________				
If yes, takes **medications** for osteoporosis?	☐	☐	☐	☐
If no, ever had a test for osteoporosis (brittle bones)?	☐	☐	☐	☐
• Have **mobility problems**? *If yes*, describe*:*______________________	☐	☐	☐	☐
• Use mobility aids, such as canes, walkers?	☐	☐	☐	☐
• Use **special shoes** or **splints**?	☐	☐	☐	☐
• Have **protective devices**? (e.g., head gear for head banging or frequent falls)	☐	☐	☐	☐
If yes, describe*:* ______________________________				
• **Other**: ______________________________				

Muscles, joints and Mobility

© 2013 Surrey Place Centre

8. NERVOUS SYSTEM: Does this person… [5] *If yes*, use **Seizure Chart** *and* **Protocol**	NO	DON'T KNOW	YES	If YES, CHANGE in past year?
• Have **seizures**? *If yes*, date of last seizure (dd/mm/yyyy) ________________	☐	☐	☐[5]	☐
• Have recent **changes** in seizure patterns? Describe: ____________________	☐	☐	☐[5]	☐
• **Faint**?	☐	☐	☐	☐
• Complain of **headaches or dizziness**? *If yes*, how often? ____________________	☐	☐	☐	☐
• Seem **unsteady when walking** or **fall**? Last fall (dd/mm/yyyy): ______________	☐	☐	☐	☐
• Have **weakness, numbness or tingling** in their **arms** or **legs**?	☐	☐	☐	☐
• Have shaky or **uncontrollable movements** or **tics**?	☐	☐	☐	☐
• **Cognitive** changes?	☐	☐	☐	☐
• **Other**: ____________________				
9. SKIN: Does this person have…				
• Any **skin or nail problems**, e.g., rash, bruises, sores, redness? *If yes*, describe: ____________________	☐	☐	☐	☐
• **Dry skin**? *If yes*, where: ____________________	☐	☐	☐	☐
• Any **moles**?	☐	☐	☐	☐
If yes, changes in appearance?	☐	☐	☐	☐
• **Pressure sores** (e.g., from bed or wheelchair) in the past, or at present?	☐	☐	☐	☐
• Any current **open wounds**?	☐	☐	☐	☐
• **Other:** ____________________				
10. THYROID and HORMONES: Does this person have…				
• **Diabetes**? *If yes:*	☐	☐	☐	☐
• What type? ☐ Type 1 ☐ Type 2 ☐ Don't know				
• Controlled by? ☐ Diet ☐ Medications by mouth ☐ Insulin				
• Who monitors their blood sugar level at home? ☐ the person with DD ☐ caregiver ☐ no one				
• Is a **diabetic foot hygiene protocol** in place? *Problems, comments:* ____________________	☐	☐	☐	☐
• **Thyroid disease**? *Last blood test:* ____________________	☐	☐	☐	☐
• A change in **libido/sex drive**? *If yes,* ☐ increase *or* ☐ decrease?	☐	☐	☐	☐
• A **cold or heat intolerance**? *If yes,* ☐ cold *or* ☐ heat?	☐	☐	☐	☐
• **Other**: ____________________				
11. BEHAVIOUR: Does this person…				
• Have any **problem/distressed behaviours** (e.g., aggression, self-harm, destruction of property, sexually inappropriate)? *If yes*, describe:	☐	☐	☐	☐

Side labels: Nervous System; Skin; Thyroid and Hormones; Behaviour

© 2013 Surrey Place Centre

12. MENTAL HEALTH:

Does this person… | [1] *If yes*, consider using a **Sleep Chart**

(Side label: Mental Health)

	NO	DON'T KNOW	YES	If YES, CHANGE in past year?
• Have any recent **changes in mood** – seem moody, irritable? Usual mood (describe): ______	☐	☐	☐	☐
• Seem **anxious**?	☐	☐	☐	☐
• Seem more **withdrawn** from others?	☐	☐	☐	☐
• Have recent changes in **energy or activities**?	☐	☐	☐	☐
• Have **trouble sleeping**?	☐	☐	☐ [1]	☐
• Have any **recent personal losses** or major **life stressors**?	☐	☐	☐	☐
• Have any changes in **memory**?	☐	☐	☐	☐
• Have been abused? *If yes,* ☐ Sexual ☐ Physical ☐ Psychological *Comments:* ______	☐	☐	☐	☐
• Have been neglected?	☐	☐	☐	☐
• Have a diagnosed **psychiatric disorder**? *If yes,* ☐ Mood (e.g., depression, bipolar) ☐ Anxiety ☐ Psychotic illness *Comments:* ______	☐	☐	☐	☐
• Has the person ever had a **hospital admission** for psychiatric reasons? *If yes*, when? ______ For how long? ______ How many times? ______ *Comments:*______	☐	☐	☐	☐

13. INFECTIOUS DISEASES

NB: ***Universal Body Substance Precautions*** *are* ***essential*** *for infection prevention*

(Side label: Infectious Diseases)

Name of infectious disease	Has person ever been tested?		Has person ever been diagnosed with this disease?	
MRSA	☐ Yes	☐ Don't know	☐ Yes (year:______)	☐ Don't know
VRE	☐ Yes	☐ Don't know	☐ Yes (year:______)	☐ Don't know
C. Difficile	☐ Yes	☐ Don't know	☐ Yes (year:______)	☐ Don't know
Hepatitis B	☐ Yes	☐ Don't know	☐ Yes (year:______)	☐ Don't know
Hepatitis C	☐ Yes	☐ Don't know	☐ Yes (year:______)	☐ Don't know
HIV	☐ Yes	☐ Don't know	☐ Yes (year:______)	☐ Don't know
Other:______	☐ Yes	☐ Don't know	☐ Yes (year:______)	☐ Don't know

Are **Universal Body Substance Precautions** used by caregivers where the person lives?
☐ Yes ☐ No ☐ Don't know

OTHER IMPORTANT HEALTH INFORMATION

	NO	DON'T KNOW	YES
• Has this person ever had any **operations (surgeries)?** *If yes*, please list type of surgery and year, or patient's age when it occurred:	☐	☐	☐
• Has this person ever been **hospitalized**, or **seriously ill**? *If yes*, please list:	☐	☐	☐

Surgeries:

Type of Surgery	***Year <u>OR</u> Patient's Age***
______	______
______	______
______	______

Hospitalizations:

Hospitalization (and why) or serious illness	***Year <u>OR</u> Patient's Age***
______	______
______	______
______	______
______	______

© 2013 Surrey Place Centre

HEALTH CARE PROVIDERS AND SPECIALISTS

Name	Tel. #	Last exam or check-up done (dd/mm/yyyy)	Next Appointment	Comments
Family Physician: Dr.				
Nurse/Nurse Practitioner:				
Pharmacy: **Pharmacist:**				
Dentist: Dr.				
Eye Doctor: Dr.				
Audiologist: (hearing check-up)				

Other health professionals, specialists involved in person's care:

Name	Tel. #	Last exam or check-up done (dd/mm/yyyy)	Next Appointment	Comments/ Specialty

REFERENCES USED TO DEVELOP CAREGIVER HEALTH ASSESSMENT:

Sullivan W, Berg JM, Bradley E, Cheetham T, Denton R, Heng J, et al. Primary care of adults with developmental disabilities: Canadian consensus guidelines. Canadian Family Physician. 2011; 57: 541-553.

Lennox N. *Comprehensive health assessment program (CHAP)*, Version 5. 2005.

Massachusetts Department of Developmental Services. Health Review Checklist (Form HC-2). Revised 08 October 2007.

RESOURCES:

[1] Sleep Chart, [2] Weight Chart, [3] Bowel Movements Chart, [4] Menses Chart, and [5] Seizures Chart and Seizure Protocol are available for downloading at www.surreyplace.on.ca/Primary-Care/Pages/Home.aspx under *Tools for caregivers.*

Developed by Caregiver Tools Working Group, chaired by Angela Gonzales, Clinical Nurse Specialist, and Maureen Kelly, Registered Nurse, at Surrey Place Centre.

© 2013 Surrey Place Centre