

Name: _____

Date of Birth: _____ **Marital Status:** Single ___ Married ___ Widowed ___
Other _____

Social Security Number _____

Address: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Emergency Contact: _____

Phone: _____

Caregiver Information:

Name of Person: _____

Address, if not same: _____

Medical Conditions of caregiver:

Current perception of health status: _____

Knowledge of wellness and self-care: _____

Medical Doctor/PCP Name: _____

Specialists/Type: _____

Fall Risk Assessment: _____

Functional Abilities: _____

Performance of activities of daily living (bathing, dressing, cooking, telephone use, financial management, grocery shopping, housework, laundry, transportation), and if unable to do, who performs these tasks:

Emotional Issues:

Depression/medication: _____

Coping capacity:

Anxiety/Medication: _____

Social Isolation: _____

Caregiver Burnout: _____

Grief Issues: _____

Spiritual Needs, if any: _____

Environmental Issues:

Home Safety: _____

Accessibility of Home Environment: _____

Name of Carrier and I.D. and/or group number of all Health Insurance Cards including Co-Insurance: _____

Insurance Company Telephone Numbers: _____

Important Phone Numbers/Caregivers/providers: _____

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What types of care do you provide? _____

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What kinds of support do you have? _____

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What do you hope to gain from this support group? _____

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What do you hope to share with group members? _____

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This group will meet every other week. Please inform facilitator if you are unable to attend as close to meeting as possible. Payment will be appreciated at each meeting. Thank you so much for your attention and respect for all other caregivers in the group.

I hereby give Caryl Diengott, MSW, LICSW, C-ASWCM, CSW-G to have the access to and contact with any and all colleagues, medical personnel to help facilitate community resources on your behalf, if needed.

Signed: _____

Date: _____