

# CARE RECEIVER'S NEEDS LIST

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

	Yes	No	Sometimes	Comments
Understands own needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asks for help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Doesn't like being helped	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gets around independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Needs help to eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Needs help to bathe or shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Needs help to dress and undress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Needs help to use toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Needs help with mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is incontinent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is bedridden	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Needs supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Needs help fixing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uses a wheelchair or walker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Needs help with medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Special Concerns:</b>				
Visually impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confused or disoriented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depressed or anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Help Needed With:</b>				
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Light housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Meal preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Special Information:</b>				
Hobbies & favorite activities:	_____			
Favorite foods:	_____			
Favorite clothes:	_____			
Exercise needs:	_____			
Dietary needs:	_____			
Difficult behavior:	_____			
Emergency safety issues:	_____			
Special issues related to personal habits such as smoking; pets; sensitive conversation topics; religious, ethnic or racial biases:	_____			