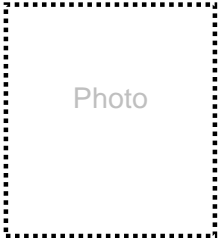




Marion County Sheriff's Office
Project Lifesaver Client Profile
"Being There When Needed"



Client Name: _____ Client Number: _____
Frequency: 216. (Frequency assigned by the Marion County Sheriff's Office)

Personal Data Questionnaire

This form is designed for Custodial 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 the necessary information to establish a more effective search response.

Care Giver/Contact Information:

Primary Contact Person Name: _____
 Relationship to Client: _____
 Full Address: _____
 Home Phone: _____ Work Phone: _____ Other: _____

Please list two (2) additional Contacts

Contact Person Name: _____
 Relationship to Client: _____
 Full Address: _____
 Home Phone: _____ Work Phone: _____ Other: _____

Contact Person Name: _____
 Relationship to Client: _____
 Full Address: _____
 Home Phone: _____ Work Phone: _____ Other: _____

Client Information:

Client's Name: _____
 Full Address: _____
 Phone: _____
 What reaction does Client have if injured? (Cry, shout,) _____
 Will Client talk to strangers? YES NO
 Is the Client DANGEROUS to himself/herself or others? YES NO

Client's Personal Data:

Birthdate: _____ Sex: Male Female Race: _____
 Nickname(s): _____
 Most recent address: _____
 Most recent place of work: _____
 Most recent occupation: _____
 Name of Spouse: _____ Spouse is Living Deceased
 If Client does not understand English, what language is understood?
 Spoken word only? YES NO Written and Spoken
 Attending Physician: _____ Phone No. _____
 Diagnosis: _____

Client's Physical Description:

Height: _____ feet _____ inches Weight: _____ pounds Build _____

Hair color _____ Hair style _____ Eye Color _____

Complexion _____ Beard YES NO Sideburns YES NO

Mustache YES NO Balding YES NO False Teeth YES NO

Shape of facial features: Round Square Oval Other _____

Distinguishing marks, scars, tattoos, etc. Describe _____

Does Client wear glasses? YES NO Contacts? YES NO Sunglasses YES NO

If Client wears glasses or corrective eyewear, what degree of vision does he/she have without the eyewear:
 None Poor Fair

Does Client wear a hearing aid? YES NO what style? _____

If yes, what type of hearing without aid? None Poor Fair

Health/Psychological Condition:

Any known physical handicaps (Describe please) _____

Any known medical problems (Describe please) _____

List medication taken regularly using correct name of drug and dosage being taken:

Consequences of NOT taking medications: _____

Any Psychological Issues YES NO Nature: _____

Personal Articles Normally Carried by the Client:

Tobacco Products: YES NO Brand: _____

Candy/Gum: YES NO Brand: _____

Matches: YES NO Lighter: YES NO Type: _____

Food Items: _____

Facial tissue YES NO

Purse or Wallet: Color _____

Approximate Amount of Cash on Hand? \$ _____ Where Normally Carried: _____

Jewelry (Please describe) _____

Watch YES NO Color: _____

Equipment:

Cane Walker

Experience:

Familiar with area YES NO How recently _____ Days Months Years

If not local, what other areas are known to Client _____

Ever go out alone YES NO Stay on trails? YES NO

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* _____

Job duty in Military _____

Recreational Outdoor Experience YES NO Type _____

Hunting YES NO Fishing YES NO

Overnight Camping Experience YES NO _____

General Athletic Interest/Abilities _____

Ever wandered before? YES NO **Where** _____

When _____ **Time of Day** _____

Located by searchers or returned by himself/herself? _____

Location found _____

Actions taken _____

Personality Habits

Smoke YES NO How often _____ Brand _____

Drink Alcohol YES NO Brand _____

Hobbies/Interests _____

Outgoing Quiet Likes: Groups Being alone

Evidence of Leadership? YES NO Explain _____

Ever been in trouble with the law? YES NO Explain _____

Religious YES NO What faith? _____

What does Client value most? _____

Which family member is Client closest to? _____ Relationship: _____

Where was Client born and raised? (city,state) _____

Has Client received any letters recently? YES NO From Whom? _____

Client's Fears: (Check all that apply)

Dogs People Noises The Dark Horses Other _____

Client a Member of any Organization: (Example: Amvets, AARP, MRDD)

Family/Friend Information: *Other persons the Client might contact (family, friends, etc.)*

Name: _____ Phone: _____

Address: _____

Relationship to client: _____

Name: _____ Phone: _____

Address: _____

Relationship to client: _____

Responsible Party Paying for client: _____

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Internal Use Only

Date Transmitter Placed:

Facility/Organization: Marion County Sheriff's Office Phone: 740-382-8244

Address: 889 Marion Williamsport Rd. E., Marion OH 43302

PL Servicer filling out this form: _____

PL Servicer that places transmitter on: _____

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

Does the Client remain oriented to Time and Person? YES NO

Explain: _____

Does the Client recognize familiar persons and faces? YES NO

Explain: _____

Can the Client travel to familiar locations? YES NO

Explain: _____

Does the Client have decreased knowledge of current events or tend to re-live events in his/her life? YES NO

Explain: _____

Does the Client sometimes clothe himself/herself improperly? YES NO

Example: Putting shoes on the wrong feet, adding underwear over clothing?

Explain if necessary: _____

Does the Client remember his/her own name and the names of spouse and or children? YES NO

Explain: _____

What is the Client's sleep pattern? YES NO

Explain: _____

Does the Client suffer from frequent personality and emotional changes? YES NO

Explain: _____

Does the Client suffer from delusions
Example: *See Imaginary Visitors, Talk to his/her own reflection in the mirror, Imagine that their spouse is an imposter, etc?* YES NO

Explain: _____

Does the Client have a valid driver's license? _____(OLN #) YES NO

Does the Client have access to a vehicle?*(Make, Model, Description) _____ YES NO

***Client should not have access to a vehicle or keys to family vehicles.**

How good is the Client's communication ability? None Poor Fair Good Excellent