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:		

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 _____ ☐ Don't know
(relationship) (type of DD)
☐ Yes _____
(relationship) (type of DD)

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 _____ ☐ Don't know
(relationship) (type of illness)
☐ Yes _____
(relationship) (type of illness)

DIABETES
☐ Yes _____ ☐ Don't know

CANCER
☐ Yes _____ ☐ Don't know
(relationship) (type of cancer)
☐ Yes _____
(relationship) (type of cancer)
☐ Yes _____
(relationship) (type of cancer)

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:	

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: _____

2. HEART and CIRCULATION OF BLOOD:

Does this person…

Heart and Circulation

	NO	DON'T KNOW	YES	If YES, CHANGE in past year?
• 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)?	☐	☐	☐[2]	☐
If yes, ☐ intentional ☐ unexplained				
• 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)?	☐	☐	☐	☐

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**: _____				

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?
Women's Health				
• **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)_____	☐	☐	☐	☐

6. C. MEN'S HEALTH:

Does this person…

Men's Health				
• 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): _____				

7. MUSCLES, JOINTS and MOBILITY:

Does this person… (focus on any change in mobility/walking) *If yes, consider keeping a pain record*

Muscles, joints and Mobility				
• 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**: _____				

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?
Nervous System				
• Have **seizures**?	☐	☐	☐[5]	☐
If yes, date of last seizure (dd/mm/yyyy) _____				
• Have recent **changes** in seizure patterns?	☐	☐	☐[5]	☐
Describe: _____				
• **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…

Skin				
• 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…

Thyroid and Hormones				
• **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…

Behaviour				
• Have any **problem/distressed behaviours** (e.g., aggression, self-harm, destruction of property, sexually inappropriate)? *If yes*, describe:	☐	☐	☐	☐

12. MENTAL HEALTH:

Mental Health

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

Infectious Diseases

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

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:	☐	☐	☐

Type of Surgery	***Year OR Patient's Age***
_____	_____
_____	_____
_____	_____

	NO	DON'T KNOW	YES
• Has this person ever been **hospitalized**, or **seriously ill**? *If yes*, please list:	☐	☐	☐

Hospitalization (and why) or serious illness	***Year OR Patient's Age***
_____	_____
_____	_____
_____	_____
_____	_____

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 Angie Gonzales, Clinical Nurse Specialist, and Maureen Kelly, Registered Nurse, Surrey Place Centre.