



# Communication Book For In Home Health Care

## Creating a Personal Profile for Your Family Member

### Personal Profile

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Place of birth: \_\_\_\_\_

Primary language used: \_\_\_\_\_

Names of parents: \_\_\_\_\_

Names of siblings: \_\_\_\_\_

If married, name of spouse: \_\_\_\_\_

Names of children: \_\_\_\_\_

Names of grandchildren: \_\_\_\_\_

Religious affiliation, is important: \_\_\_\_\_

Education: *where they went to high school, where they went to college, what they studied* \_\_\_\_\_

Branch of military service: \_\_\_\_\_

Jobs/career path, prior to retirement: \_\_\_\_\_

Professional and volunteer organizations: \_\_\_\_\_

\_\_\_\_\_

Awards/honors etc.: \_\_\_\_\_

Hobbies: \_\_\_\_\_

\_\_\_\_\_

**Community activities:** *movies, sports, eating out* \_\_\_\_\_

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**Special interests:**

**Favorite places:**

**Likes:** *this section would address such topics as favorite foods, what they like to wear, what kind of music they like to listen to, prefers room temperature water versus hot water, anything specific to your care recipient*

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**Dislikes:** *this section would address such topics as things your family member does not like. Foods they don't care to eat, prefers showers to taking a bath etc. I dislike should be specific to things that may make your family member uncomfortable to things that they may be adamant about*

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**Names of pets:** \_\_\_\_\_

**Favorite topics of discussion:** \_\_\_\_\_

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*If you have a family member that has memory impairment, or a form of dementia, putting together a small purse sized photo album of important people and places would be beneficial. As the disease progresses, pictures with people and places, noted to identify those in the photo, will help others caring for your family member to carry on a conversation that is important and individualized to your family member.*

**Important things to do to ensure health and safety:** *This would include using assistive devices, encouraging healthy snacks, encouraging exercise, reminding to walk with walker, etc.*

\_\_\_\_\_

\_\_\_\_\_



## Determining Home Care Needs – The Assessment

This part of the assessment will be kept in a separate area that is specific to the caregivers regarding the functional abilities, skills, and personality and behaviors.

### Personality and Behaviors

Here is a checklist of traits that may describe the personality and behaviors that may best describe your family member to others:

- Happy all the time
- Suffers from depression
- Frustrates easily
- Poor short-term memory
- Likes to sleep during the day
- Awake all night
- Sleeps too much
- Sleeps too little
- Irritable
- Has a tendency to wander
- Repeats stories and questions
- Sensitive, cries easily
- Hallucinates
- Incontinent of bowel or bladder
- Angers easily
- Constant worrier
- Anxious
- Other- please explain \_\_\_\_\_



## Abilities and skills with activities of daily living:

This checklist will identify abilities and functions related to activities of daily living. Identify any functions that a person needs complete assistance with a task, require some assistance with the task, or is totally independent in completing the task.

- Going to the bathroom
- Bathing or showering
- Brushing teeth
- Taking medications
- Dressing upper body
- Dressing lower body
- Putting shoes and socks on
- Shaving
- Combing hair

### Preparing food:

- Can they use a microwave?
- Do they cook?
- Do they reheat food?
- Do they use the stove?

### Eating:

- Do they need their food cut up?
- Are they on a special diet?
- Do they need help with eating?
- Do they use assistive devices?



Drinking:

- Do they use assistive devices?
- Do they have special cups?
- Do they require liquids to be thickened?
- Do they need to avoid hot or cold beverages?
- Are there certain liquids they cannot have, such as juices, because of potential medication interaction?

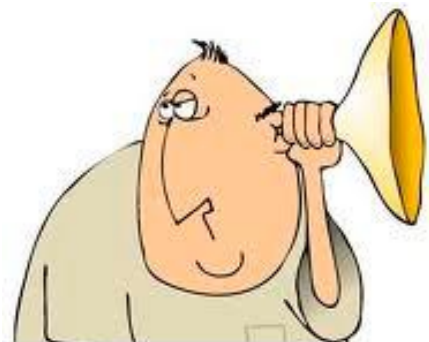
Household tasks:

- Are they able to run the sweeper, dust, do laundry, take out the garbage or other tasks to maintain the household? Should they be encouraged to do these things, and if so, which tasks? \_\_\_\_\_
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**Hearing ability**

Please check the most appropriate for your family member.

- Wears hearing aids
- Is sensitive to noise
- Uses assistive devices to watch TV or listen to the radio
- Refuses to wear hearing aids
- Watches TV or listen to the radio at a very high volume
- Certain noises increase agitation or distraction: this may occur during certain times of the day or maybe caused by such things as ringing of the phone.



## Vision

- Wears glasses:
  - For reading
  - For watching television
  - For driving
  - All the time
  - Only at night
- Must wear sunglasses due to light sensitivity:
  - all the time
  - only when outside during the day



## Physical Mobility

List here any special requirements, use of assistive devices that may be required for mobility: walker, quad cane, scooter, unable to use right or left side, unable to take care of the lower part of the body or the upper part of the body.

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## Hygiene

- Refuses to bathe
- Needs coaxing to bathe
- Changes clothes frequently
- Insists on wearing clothes that are not appropriate for the weather
- Has difficulty changing clothes
- Is incontinent and not able to tell you when they have to go to the bathroom
- Have difficulty finding the bathroom
- Insists on wearing the same clothes over and over again
- Other: be specific \_\_\_\_\_



**Personal Preferences**

Use this section to be very specific. If your family member likes boiled eggs at 3 minutes, every morning with lightly toasted wheat bread. WRITE IT DOWN. If they like honey in their tea, WRITE IT DOWN.

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If household duties are to be expected, such as changing the linen, determine a day. Be specific about the laundry setting and laundry soap, if that is important to you.

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In the **OTHER** section of the agreement/contract you may want to put a mention of things written on the white board as Activities of the Day.



### Personal preferences/clothing

Please check off what is important to your family member:

- Prefers to wear little or no clothing
- Is always cold, likes to wear a sweater
- Prefers to be dressed up every day
- Prefers to be dressed in layers
- Likes loose-fitting clothing
- Likes to wear pants with elastic waistband
- Is always hot
- Is always cold
- Prefers socks
- Prefers stockings
- Prefers to wear slippers, instead of shoes
- Prefers to wear sandals
- Must wear orthopedic shoes
- Likes to wear flats
- Likes to wear heels
- Likes to wear tennis shoes



Special considerations with clothing may include prefers Velcro to buttons, has sensitivity to some fabrics, prefer suspenders to a belt etc.

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Other:

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**Personal preferences/activities**

Your family member has a daily routine. They do certain activities in the morning, afternoon, evening and at meals. Here is a checklist of things that might be important to your family member, that an outside caregiver would appreciate knowing.

Identify if these are things or settings that your family member may utilize in the morning, the afternoon, the evening, at bedtime, or at meals.

Do they have a favorite chair they sit in? \_\_\_\_\_

Do they have a special spot on the couch where they sit? \_\_\_\_\_

Did they spend time in bed during the day? \_\_\_\_\_

Do they have a table they utilize on a regular basis? \_\_\_\_\_

Do they like to spend time in the bedroom, the living room, or the outside, and when? \_\_\_\_\_

Do they like to walk? \_\_\_\_\_

Do they like to go to the movies? \_\_\_\_\_

Do they like to go out to eat? \_\_\_\_\_

Do they like to visit with neighbors? \_\_\_\_\_

Do they like shopping? \_\_\_\_\_

Read the newspaper, online or is it delivered to the house? \_\_\_\_\_

Read magazines? \_\_\_\_\_

Work or play games on the computer? \_\_\_\_\_

Favorite TV shows and schedule \_\_\_\_\_

Favorite radio shows and schedule \_\_\_\_\_

Do they like to play cards? \_\_\_\_\_

Do they like to play games? \_\_\_\_\_

Do they continue to have social activities or participate in social functions? \_\_\_\_\_

Do they have specific religious rituals or prayers that they perform every day? \_\_\_\_\_

Places to avoid:

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## Personal preferences/food

List favorite foods and drink preferences here:

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The special food and drink considerations: special diets, restrictions, identify normal meal and snack times. Identify any use of special cups, plates or utensils. If there are specific things that will make mealtime more pleasant for your family member, this is a good place to identify those needs. Specific things may be food must be placed on the right or left side of a person because of their field of vision being affected, they need to be encouraged to eat slowly, they are beginning to have swallowing difficulties and need to be monitored for choking.



### Personal preferences/daily hygiene

In this section, identify special things that your family member is accustomed to and anything special that the outside caregiver must take into consideration. This will ensure consistency and help maintain a routine, which will be of comfort to your aging family member.



Do they prefer a bath or shower? Time of day? Any special instructions?

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#### Mouth care:

Type of toothpaste \_\_\_\_\_  
Type of toothbrush \_\_\_\_\_  
Use of mouthwash? \_\_\_\_\_  
Swallowing concerns? \_\_\_\_\_  
What time of day do they brush? \_\_\_\_\_  
How many times of day do they brush their teeth? \_\_\_\_\_  
Do they wear dentures? \_\_\_\_\_

#### Hair care:

Times of day they wash their hair \_\_\_\_\_  
How many times a week? \_\_\_\_\_  
Any special instructions? \_\_\_\_\_

#### Fingernails:

How often do they do their nails? \_\_\_\_\_  
Do they prefer them cut or filed? \_\_\_\_\_  
Any special instructions? \_\_\_\_\_



Toenails:

How often do they see the podiatrist? \_\_\_\_\_

Any special instructions? \_\_\_\_\_

Skincare:

Preferred lotions or treatments \_\_\_\_\_

Times of treatments \_\_\_\_\_

Any special instructions? \_\_\_\_\_

Face care:

Times of day for face care \_\_\_\_\_

Preferred products \_\_\_\_\_

Any special Instructions? \_\_\_\_\_

Lip care:

Balms, moisturizers or lipstick? \_\_\_\_\_

Any special Instructions? \_\_\_\_\_

Bedridden:

Every two-hour turn schedule \_\_\_\_\_

Special treatments \_\_\_\_\_

Any special instructions? \_\_\_\_\_

Bedding change schedule \_\_\_\_\_

Mattress protection \_\_\_\_\_

Pillows placement \_\_\_\_\_

Covering desired \_\_\_\_\_

Incontinence product:

Types \_\_\_\_\_

Times of use \_\_\_\_\_

Any special instructions? \_\_\_\_\_