Northwest Missouri Area Agency on Aging
Family Caregiver Assessment

Assessor Name: ____**Date:** _____________
□ Temporary Address ☐Other
Source of Information: ☐Client ☐Other (specify name/relationship) ________________________

Referred for: (check all which apply):
□FCG Respite □ FCG Personal Care □FCG Homemaker

Client Information (Complete for Caregiver)

Last Name: ____________________ First Name: _______________ MI ____ Nickname: _________

☐ Male ☐Female DOB______________ SSN_____________________

Address__________________________________ Caregiver_________________________________

City_________________________ State__________ County____________________ Zip___________

☐Rural ☐Urban Phone_________________________ E-mail Address________________________

Client Information (Complete for Care Recipient)

Last Name:_______________________ First Name: _______________MI: ____Nickname:_________

☐ Male ☐Female DOB______________ SSN___________________

Address_____________________________________ Caregiver______________________________

City_______________________ State__________ County____________________ Zip___________

☐Rural ☐Urban Phone______________________________ E-mail Address___________________
_

Martial Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated ☐Partnered

Eligibility: ☐Age ☐Spouse of Eligible ☐Disabled 18-59 ☐Disabled living in Senior Housing

Ethnicity: ☐Hispanic ☐Non Hispanic **Veteran (Spouse of)** ☐ Yes ☐No Branch of Service __________
Year of Discharge _________

Primary Race: ☐African American ☐Hispanic ☐American Indian/Native Alaskan
☐Asian/Pacific Islander ☐Caucasian ☐Other

US Citizen ☐Yes ☐No **Speaks English** ☐Yes ☐No

Living Arrangements: Number of People in the household_____________
☐House ☐Duplex ☐Apartment ☐Senior Housing ☐Assisted Living ☐Mobile Home ☐Homeless
☐Other_________________________________

Residence is ☐Owned ☐Rented ☐Other____

First Emergency Contact (Does this person know they are your emergency contact?) ☐Yes ☐No
Name ____Relationship___________________________________
Address _______________________________City __________________ State _________Zip____________
Home Phone___________________________ Cell Phone________________________

Second Emergency Contact (Does this person know they are your emergency contact?) ☐Yes ☐No
Name ____________________________________Relationship___________________________________
Address _______________________________ City __________________ State _________Zip__________
Home Phone___________________________ Cell Phone________________________

Clergy Member: _______________________________ Clergy Phone: ______________________________

COGNITIVE SCREENING (Complete for Care Recipient)
I would like to ask you some questions to test your memory and concentration. Some may be easy and some may be hard, but please try to answer them all. **(Enter zero if the client gets the answer correct.)**
☐Client refused ☐Client not the source of information
Years of Education_________

	Max Err	Weight	Total
1. What year is it now? _________	1_____	x 4	______
2. What month is it now?	1_____	x 3	______
3. What is your full name?	1_____	x 4	______

4. Please repeat this phrase after me: John Brown, 42 Market Street Chicago IL. **Tell client to remember this because you will ask again later.**
Number of trials to learn_______

5. Count backwards from 20-1. Mark correctly sequenced numerals.
☐ 20 ☐19 ☐18 ☐17 ☐16 ☐15 ☐14 ☐13 ☐12 ☐11 ☐All correct
☐ 10 ☐9 ☐8 ☐7 ☐6 ☐5 ☐4 ☐3 ☐2 ☐1 2_____ x 2 ______
6. What time of the day is it without looking at your watch 1_____ x 3 ______
Response time___________ Actual time___________

7. Say the months of the year in reverse order starting with December.
☐ Dec ☐Nov ☐Oct ☐Sept ☐Aug ☐July ☐ All correct
☐ June ☐May ☐Apr ☐Mar ☐Feb ☐Jan 2_____ x 2 ______

8. Repeat the phrase given to you earlier
John Brown 42 Market Street Chicago 5_____ x 2 ______

Total Score ________

Short Blessed Score
0-6 Normal to Minimum Impairment
7-19 Minimum to Moderate Impairment
20-28 Severe Impairment
If the total is 16 or higher the client may need a proxy to complete this form.

Complete for Care Recipient

<u>NUTRITION RISK ASSESSMENT:</u> Possible answers to questions: Y = yes (true) N = no (false) E = elects not to answer.

Question	Y	N	E
Do you have an illness or condition that has made you change the kind or amount of food you eat			
Do you eat fewer than 2 meals a day			
Do you eat few fruits or vegetables, or milk products			
Do you have 3 or more drinks of beer, liquor or wine almost every day			
Do you have teeth or mouth problems that make it hard for you to eat			
Do you always have enough money to buy the food you need			
Do you eat alone most of the time			
Do you take 3 or more different prescribed or over the counter drugs a day			
Without wanting to, have you lost or gained 10 pounds in the last 6 months			
Are you always physically able to shop, cook and/or feed yourself			

Has your doctor recommended any special diet(s)? ☐Yes ☐No

	Recommended	Followed	Comments
Low Sodium	☐	☐	________________
Diabetic	☐	☐	________________
Low fat/cholesterol	☐	☐	________________
Renal/Kidney	☐	☐	________________
Nutrition Supplements	☐	☐	________________
6 Small meals daily	☐	☐	________________
Vegetarian	☐	☐	________________
Pureed	☐	☐	________________
Weight reduction	☐	☐	________________

MEAL PREPARATION
ASK CLIENT: Does anyone help prepare or bring food to you? ☐Yes ☐ No
If yes, ask the following:

1. Who helps prepare your meals (specify) _________________ ☐Family/Spouse ☐In-home worker

2. What meal(s)

Breakfast	☐S	☐M	☐T	☐W	☐T	☐F	☐S
Lunch	☐S	☐M	☐T	☐W	☐T	☐F	☐S
Dinner	☐S	☐M	☐T	☐W	☐T	☐F	☐S

3. Check any item(s) which affect your ability to eat: ☐Choking ☐ Choking on liquids ☐Swallowing ☐Taste ☐Nausea/Vomiting ☐Cutting up food ☐ Opening containers ☐Vision ☐Dentures (lack of/ill fitting) ☐None

FUNCTIONAL ASSESSMENT (Complete for Care Recipient)
0=Completes the task independently 3=Occasional Assistance or supervision may be necessary
6= Assistance or supervision is always necessary 9=Totally dependent on others
In the comment section, how much help is provided and how often

ACTIVITIES OF DAILY LIVING(Complete for Care Recipient)

Activity	Indep 0	Min 3	Mod 6	Max 9	Primary help source	Comments
Eating						
Bathing						
Grooming						
Dressing						
Toilet use						
Mobility						
Transferring						

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (Complete for Care Recipient)

Activity	Indep 0	Min 3	Mod 6	Max 9	Primary help source	Comments
Laundry						
Shopping						
Light Housework						
Heavy Housework						
Telephone						
Financial Management						
Transportation						
Meal Prep						
Med Manage						

ADAPTIVE EQUIPMENT (Complete for Care Recipient)

Equipment	Has	Has but does not use	Needs	Comments
Bathing Equip				
Brace Prosthesis				
Cane, Crutches				
Diabetic Supplies				
Dentures				
Railings				
Hospital Bed				
Medical Phone Alert				
Toilet Equipment				
Walker				
Wheelchair				
Other Specify				

TRANSPORTATION NEEDS (Complete for Care Recipient)

1. Do you drive? ☐Yes ☐No   2. Do you have a car? ☐Yes ☐No If yes, is the car insured? ☐Yes ☐No

If caregiver/care recipient has a car but does not drive, does someone else drive him/her places? ☐Yes ☐No

If yes, specify who drives the caregiver/care recipient: ____

Can you walk from inside your home to the curb? ☐Yes ☐ No
Can you carry 10 pounds without assistance? ☐Yes ☐ No
Do you need a vehicle with a wheelchair lift? ☐Yes ☐ No

PLACE OF RESIDENCE - OBSERVATION
What floor does the client live on? _____ Is the bathroom on the same floor? ☐Yes ☐ No
If the client lives on other than the main floor: Is there an elevator, lift, or stair lift? ☐Yes ☐ No
Number of steps to enter home: _____ Are steps a problem within the home? ☐Yes ☐ No

Ask the care recipient the following questions:
Do you have difficulty getting into your home? ☐Yes ☐ No
Do you have difficulty getting into any room in your home? ☐Yes ☐ No

Comments:____
____

FALL RISK SCREEN (Complete for Care Recipient)

1. How many times have you fallen in the past year? _____

2. Are you worried that you might have a fall?
☐Not at all worried ☐A little worried ☐Somewhat worried ☐Very worried

3. Do you limit activities now because of fall-related concerns?
☐ Never ☐ Occasionally ☐ Sometimes ☐ Often

If client has not fallen in the past year, skip questions 4 & 5

4. Where have you fallen? ☐Getting in and out of bed ☐Bathroom ☐Outside the home
☐Between the bed & the bathroom ☐Kitchen
☐Other (specify)
____

5. Can you say what makes you more likely to fall? ☐Feeling dizzy/lightheaded ☐Getting up quickly
☐Walking in darkness ☐Dim lighting ☐Certain shoes ☐Turns ☐Stairs ☐Walking on certain surfaces
☐Other (specify) ____

MEDICAL PERSONNEL (Complete for Care Recipient)
Information not available because (specify) ____

Primary Doctor ____ Phone ___________________________

Specialist(s): List specialists **including** address and phone number.

Name	Address	Phone
1. ______________________________	______________________________	______________________
2. ______________________________	______________________________	______________________
3. ______________________________	______________________________	______________________
4. ______________________________	______________________________	______________________
5. ______________________________	______________________________	______________________

Pharmacy(s): List all pharmacies used **and** their phone numbers

Name	Address	Phone
1. ______________________________	______________________________	________________________

In-home provider name: ______________________ Phone: ___________________ ☐Short-term ☐Long-term
Dentist: ___________________________________ Phone: ____________________
Hospital Preference: ____

PRESCRIPTIONS

List all medications that you are currently taking. Please include all prescribed, over the counter medications and supplements.

Date Started:	Name of Medication Dose	Directions: (Do not use medical abbreviations)	Doctor Name?	Reason for taking:

ALLERGIES: ____

SELF-MANAGEMENT OF MEDICATIONS

Ask Client: How do you remember to take your medications? (Check all that apply)

☐Calendar ☐Egg Carton/envelope/bag ☐Pill Box/Dispenser

☐Person reminds/gives/sets up: **WHO: ____________________ HOW OFTEN: ____________________**

☐Follow label directions

MEDICAL CONDITIONS (Complete for Care Recipient)

List medical conditions or other conditions that would warrant the need for Respite:

____

____

____

____

Tasks to be performed:

____

____

____

____

Maximum units (per month) recommended by the interviewer: ______________________________

____________________________ ____________________________ _______________

Signature of Client Signature of Interviewer Date

ELDERLY ABUSE/NEGLECT CHECKLIST (Complete for Care Recipient)

Interviewer: This is observational	**Yes**	**No**	**Somewhat**	**N/A**
Inadequate (too much/too little) and/or inappropriate clothing (bizarre, inside out, underwear outside of clothing)	☐	☐	☐	☐
Body Odor	☐	☐	☐	☐
Poor overall appearance (unwashed, unshaven, soiled unkempt hair, unkempt nails, dirty skin)	☐	☐	☐	☐
Signs of malnutrition/dehydration (frail, weak, tired, poor skin condition, sunken eyes)	☐	☐	☐	☐
Bruises, black eyes, welts, lacerations, and rope marks	☐	☐	☐	☐
Open wounds, cuts, punctures, and untreated injuries in various stages	☐	☐	☐	☐
Emotionally upset or agitated	☐	☐	☐	☐
Extremely withdrawn emotionally and non-communicative or non-responsive	☐	☐	☐	☐
Unusual behavior not attributed to a medical diagnosis (sucking, biting, rocking)	☐	☐	☐	☐
Substandard care being provided or bills unpaid despite the availability of adequate financial resources	☐	☐	☐	☐
Provision of services that are not necessary	☐	☐	☐	☐
Client reports being financially exploited. By whom?	☐	☐	☐	☐
Client reports being abandoned by others (at hospital, nursing home, similar institution, shopping center or other public location). By whom? ________________________	☐	☐	☐	☐
Client reports being hit, slapped, kicked, or mistreated. By whom? ________________________	☐	☐	☐	☐
Client reports of being verbally or emotionally mistreated. By whom? ________________________	☐	☐	☐	☐
Client reports of being sexually assaulted or raped. By whom? ________________________	☐	☐	☐	☐

Comments:

____

____

____

ELDER ABUSE HOTLINE 1-800-392-0210

PSYCHO/SOCIAL STATUS (Complete for Caregiver) Yes Activity Comments

- ☐ Reads books, magazines, newspapers, Bible/religious materials ______________________
- ☐ Watches television/listens to radio ______________________
- ☐ Expresses spiritual needs ______________________
- ☐ Visits with friends/family (who?) ______________________
- ☐ Participates in hobbies or crafts (type?) ______________________
- ☐ Plays games or cards (with whom?) ______________________
- ☐ Plays musical instruments (type(s)?) ______________________
- ☐ Goes to sporting events/movies/plays ______________________
- ☐ Goes out to eat ______________________
- ☐ Attends classes (where?) ______________________
- ☐ Likes to be with others ______________________
- ☐ Other ____

GERIATRIC DEPRESSION SCALE (Complete for Caregiver)

I'm going to ask you some questions about your mood and how you have been feeling over the past week or so. Please answer each question either yes or no. (If they have difficulty answering then prompt them: "Would you say more yes or more no?"

1. Are you basically satisfied with your life? ☐ Yes ☐ **No**
2. Have you dropped many of your activities and interests? ☐ **Yes** ☐No
3. Do you feel that your life is empty? ☐ **Yes** ☐ No
4. Do you often get bored? ☐ **Yes** ☐ No
5. Are you in good spirits most of the time? ☐ Yes ☐ **No**
6. Are you afraid that something bad is going to happen to you? ☐ **Yes** ☐ No
7. Do you feel happy most of the time? ☐ Yes ☐ **No**
8. Do you often feel helpless? ☐ **Yes** ☐ No
9. Do you prefer to stay at home, rather than going out and doing new things? ☐ **Yes** ☐ No
10. Do you feel you have more problems with memory than most? ☐ **Yes** ☐ No
11. Do you think it is wonderful to be alive now? ☐ Yes ☐ **No**
12. Do you feel pretty worthless the way you are now? ☐ **Yes** ☐ No
13. Do you feel full of energy? ☐ Yes ☐ **No**
14. Do you feel your situation is hopeless? ☐ **Yes** ☐ No
15. Do you think that most people are better off than you are? ☐ **Yes** ☐ No

Score **ONE** point for each answer that is in **BOLD** **TOTAL SCORE** ____________

If total score is above 5, ask client the following question: "Your score suggests you have some depression. We ask everyone who has depression..."

Do you sometimes think of ending your life?
If yes, do you have a plan?
Plan details: ____
____

Elder abuse hotline: 800-392-0210 Behavioral health response: 800-811-4760 Life Crisis: 314-647-4357

PRIMARY CAREGIVER INFORMATION (Complete for Caregiver)

1. Does the caregiver have any informal supports? ☐Yes ☐ No If yes, list in question #2

2. List informal supports:

Name/Location/Phone	Relationship to Care Recipient	Age	Help Provided

3. If the people who help you are not available, are there other persons who will assist you if asked? ☐Yes ☐ No

4. Check limitations or constraints of primary caregiver: ☐No particular constraint ☐Poor health, disable, frail
☐Lacks knowledge, skills ☐Providing care to others ☐Not reliable due to other commitments
☐Poor relationship with care recipient ☐Lives at a distance ☐Alcohol, drug abuse
☐Financial strain ☐Dependent on care recipient for housing, money or other ☐Employed

5. Current employment status? ☐Full Time ☐Part Time ☐Unemployed ☐Retired

6. Has your job or social life been affected by your caregiver duties? ☐Yes ☐No
If yes, describe: ____

7. Do you have any other care giving responsibilities? ☐Yes ☐No
If yes, describe: ____

8. How many hours a day do you have available to provide care to this care recipient? __________

9. How many hours a day, do you usually spend providing care to this care recipient? __________

10. Describe problems with continued care giving (if any) ______________________________________

11. Does the caregiver live with the care recipient? __________Yes __________No

12. Do you desire service or support? ☐Yes ☐No

13. Is anyone available to provide respite (relief) when you are unable to provide care?
☐Yes ☐No If yes, describe ____

14. In the past 6 months, have there been any significant changes in your life? ☐Yes ☐No
If yes, describe ____

15. Are you currently experiencing any emotional concerns or difficulties?
☐Yes ☐No If yes, describe____

16. Are you currently receiving any assistance to deal with your emotional concerns or difficulties?
☐Yes ☐No If yes, describe ____

17. Do you participate in a support or discussion group where you can discuss your feelings? ☐Yes ☐No
If yes, describe (type of group/freq.) ____

18. Have you ever been so upset that you did something to your relative (care recipient) that you now regret?
☐Yes ☐No If yes, describe ____

19. Has your relative (care recipient) ever done these kinds of things to you? ☐Yes ☐No

20. Overall, how stressed do you feel in caring for the care recipient?
☐Not stressed ☐**Somewhat stressed** ☐**Very stressed**
(If caregiver is *SOMEWHAT* stressed or *VERY* stressed then complete *Caregiver Stress Interview*.)

CAREGIVER STRESS INTERVIEW (Steven H. Zarit, Ph.D. –modified version)

Read to Caregiver: "The following is a list of statements which reflect how people sometimes feel when taking care of another person. After each statement, indicate how often you feel that way: Never, Rarely, Sometimes, Quite frequently, or Nearly always. There is no right or wrong answers.

Question:	Never 0 pt	Rarely 1 pt	Sometimes 2 pt	Quite Frequently 3 pt	Nearly Always 4 pt
1. Do you feel that your relative asks for more help than he/she needs?	☐	☐	☐	☐	☐
2. Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?	☐	☐	☐	☐	☐
3. Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?	☐	☐	☐	☐	☐
4. Do you feel embarrassed over your relative's behavior?	☐	☐	☐	☐	☐
5. Do you feel angry when you are around your relative?	☐	☐	☐	☐	☐
6. Do you feel that your relative currently affects your relationship with other family members or friends in a negative way?	☐	☐	☐	☐	☐
7. Are you afraid of what the future holds for your relative?	☐	☐	☐	☐	☐
8. Do you feel your relative is dependent on you?	☐	☐	☐	☐	☐
9. Do you feel strained when you are around your relative?	☐	☐	☐	☐	☐
10. Do you feel your health has suffered because of your involvement with your relative?	☐	☐	☐	☐	☐
11. Do you feel that you do not have as much privacy as you would like because of your relative?	☐	☐	☐	☐	☐
12. Do you feel that your social life has suffered because you are caring for your relative?	☐	☐	☐	☐	☐
13. Do you feel uncomfortable about having friends over because you are caring for your relative?	☐	☐	☐	☐	☐
14. Do you feel that your relative seems to expect you to take care of him/her as if you were the only one he/she depends on?	☐	☐	☐	☐	☐
15. Do you feel that you do not have enough money to care for your relative in addition to the rest of your expenses?	☐	☐	☐	☐	☐
16. Do you feel that you will be unable to take care of your relative much longer?	☐	☐	☐	☐	☐
17. Do you feel you have lost control of your life since your relative's illness?	☐	☐	☐	☐	☐
18. Do you wish you could just leave the care of your relative to someone else?	☐	☐	☐	☐	☐
19. Do you feel uncertain about what to do about your relative?	☐	☐	☐	☐	☐
20. Do you feel you should be doing more for your relative?	☐	☐	☐	☐	☐
21. Do you feel you could do a better job in caring for your relative?	☐	☐	☐	☐	☐
22. Overall, do you feel burdened caring for your relative?	☐	☐	☐	☐	☐

Total Zarit Score _____

Scoring Instructions: The Stress Interview is scored by summing the responses of the individual items. Higher scores indicate greater caregiver distress. The Stress Interview, however, should not be taken as the only indicator of the caregiver's emotional state. Clinical observations and other instruments such as measures of depression should be used to supplement this measure. Norms for the Stress Interview have not been computed, but estimates of the degrees of stress can be made from preliminary findings.

0-20= Little/No Stress
21-40=Mild/Moderate Stress
41-60= Moderate/Severe Stress
61-88= Severe Stress