PERSONAL INFORMATION SHEET
Help Us Get to Know You Better

*Please answer only what you are comfortable sharing*

Preferred Name:__________________________________________________________

Memory Impairment: YES/NO    Preferred Language:________________________________________

Preferred Method of Communication:
Sign Language    Communication Board    Other:__________________________________________

YOUR SUPPORT SYSTEM:

Who is your primary contact? ________________________________________________

Who do you share your household with? ________________________________________

TELL US ABOUT YOUR FAMILY:

Married/Single/Partner/Widow(er): Name: ________________________________   Children: YES/NO

Name(s): _______________________________________________________________

Grandchildren: YES/NO    How Many: ___________________________________________

Great Grandchildren: YES/NO    How Many: ______________________________________

Siblings: YES/NO

Other Support/Family Member(s): ____________________________________________

Your Occupation: __________________________________________________________

Years of Military Service (if applicable): ________________________________

What makes you frustrated? _______________________________________________

What makes you smile? ____________________________________________________

What is your music preference? _____________________________________________

What is your bedtime routine? _____________________________________________

What would you most importantly like the Hospital staff to know about you? ________________________________________________________________