PERSONAL LIFESTYLE PROFILE

Name:_____ Prefers to be called:_____

Spouse:_____ Living: ☐ YES ☐NO

Children:_____

DAILY ROUTINE

Awakens at:_____ To Sleep at:_____
Shower ☐ OR Bath☐ How often?_____ What time: ☐ AM ☐ PM
Sponge bath ☐

Glasses:☐Yes ☐No Hearing aids: ☐ Yes ☐ No
Dentures:☐ Upper ☐Lower ☐Both

MEALS

Eats: ☐Alone or ☐With others

Breakfast Time:_____
Usual Foods/Drinks:_____

DISLIKES:_____

Lunch Time:_____
Usual Foods/Drinks:_____

DISLIKES:_____

Supper Time:_____
Usual Foods/Drinks:_____

DISLIKES:_____

SNACKS:_____

After meal routine/chores/habits:_____
_____

ALLERGIES

_____

_____

HOBBIES/INTEREST

Individual activities:_____

_____

_____

Social activities:_____

_____

_____

BEHAVIOR

Sleep disturbance occur?☐Yes ☐ No
If yes, describe:_____

Behavioral Changes: ☐Yes ☐No If yes, what time?_____am/pm
Describe the behavior(s) and any helpful techniques used to help behavior(s):

_____

_____

_____

Any additional information you feel is important:

_____

_____

_____

_____

Completed by:_____