

# Boulder County Colorado Life Trak Client Application

## Personal Data Questionnaire

This form is designed for Custodial Care Givers to provide certain information that will help determine if a client is eligible to participate in the Colorado Life Trak program. This form will also be used to provide useful information to search teams should the need arise to establish a more effective search response.

Client's name: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Is this an assisted living facility or nursing home? \_\_\_\_\_  
If yes, what is the name of the home or facility? \_\_\_\_\_  
Nursing home or facility's phone number: \_\_\_\_\_

## Client's Personal Data

Birth date: \_\_\_\_\_ Sex: Male/Female Race: \_\_\_\_\_  
Nickname(s): \_\_\_\_\_  
Most recent home address (if they have been moved to a nursing home or facility):  
\_\_\_\_\_  
Most recent place of work:  
\_\_\_\_\_  
Most recent occupation:  
\_\_\_\_\_  
Name of Spouse: \_\_\_\_\_ Living/deceased (circle)

## Physical Description

Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. Build \_\_\_\_\_  
Hair color \_\_\_\_\_ Hair Style \_\_\_\_\_ Eye Color \_\_\_\_\_  
Glasses Yes/ No Beard Yes/ No Sideburns Yes/ No  
Mustache Yes/ No Balding Yes/ No False Teeth Yes/ No  
Shape of facial features: Round/Square/Oval/Other \_\_\_\_\_  
Distinguishing marks, scars, tattoos, etc. Describe \_\_\_\_\_  
Does the client speak English? If not, what language is understood? \_\_\_\_\_  
Does the client wear a hearing aid? \_\_\_\_\_  
If yes, what type of hearing without Aid? None/Poor/Fair (circle one)  
Does the client have vision problems? \_\_\_\_\_

If yes, what type of vision without glasses? None/Poor/Fair (circle one)

**Health/Psychological Condition**

**What is the client's cognitive disability?** \_\_\_\_\_

**Does the Client have:**

Any known physical handicaps? \_\_\_\_\_

(Describe please)

Any known medical problems?

(Describe please)

List any medication using correct name of drug and dosage being taken regularly: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Consequences of **NOT** taking medications?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attending Physician \_\_\_\_\_ Phone No. \_\_\_\_\_

**Caregiver or legal guardian's name:** \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

**Please provide a copy of documentation of legal guardianship or responsibility over client.**

**Client Behavior:**

This information will be used to assist Law Enforcement in location the client if a search is necessary.

1. **Has the client ever wandered or become lost before?** Yes/ No  
When (month/year) \_\_\_\_\_ Time of Day \_\_\_\_\_  
Where were they found and by who? \_\_\_\_\_  
Was law enforcement called? Yes/ No If yes, what agency? \_\_\_\_\_

2. **Is the client allowed to drive or do they have access to a vehicle?** Yes/ No
3. **Does the client have a bus pass or frequently ride on public transit?** Yes/ No  
If yes, where do the go? \_\_\_\_\_
4. **Does the client remain oriented to Time and Person?** Yes/No  
Explain \_\_\_\_\_
5. **Does the client recognize familiar persons and faces?** Yes/No  
Explain \_\_\_\_\_
6. **Can the client travel to familiar locations?** Yes/No  
Explain \_\_\_\_\_
7. **Does the client have knowledge of current events or do they tend to re-live events in his/her life?** Yes/No  
Explain \_\_\_\_\_
8. **Does the client sometimes clothe himself/herself improperly?** Example: Putting shoes on the wrong feet, adding underwear over clothing? Yes/ No  
Explain \_\_\_\_\_
9. **Does the client remember his/her own name and the names of spouse and or children?** Yes/No  
Explain \_\_\_\_\_
10. **Does the client suffer from frequent personality and emotional changes?**  
Yes/No  
Explain \_\_\_\_\_
11. **Does the Client suffer from delusions (See Imaginary Visitors, Talk to his/her own reflection in the mirror, Imagine that their spouse is an imposter, etc)?**  
Yes/No  
Explain \_\_\_\_\_
12. **How good is the client's communication ability?** None/Poor/Fair/Good/ Excellent
13. **Does the client need the use of a cane, walker, or Wheelchair?** Yes/ No  
If yes, describe: \_\_\_\_\_
14. **Is the client familiar with area?** Yes/ No  
How long have they lived there? \_\_\_\_\_ Days/ Months/ Years  
If not local, what other areas are known to Client? \_\_\_\_\_
15. **Is client afraid of...** Dogs? Yes/ No. The dark? Yes/ No. Noises? Yes/ No.  
Horses? Yes/ No. People? Yes/ No. Police Officers? Yes/ No  
Other (explain) \_\_\_\_\_

16. Will Client talk to or go with strangers? Yes/No

17. Is the Client DANGEROUS to him/herself or others? Yes/No (circle one)

18. Why do you feel the client is appropriate for and should be considered for participation in Colorado Life Trak?

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19. Is the applicant a client of *IMAGINE!*? Yes/No (circle one)

If yes, who is their case worker? \_\_\_\_\_

I affirm that the information is true and accurate to the best of my knowledge. I understand that providing false and/or inaccurate information may result in a denial of the applicant's acceptance into the program.

I am aware that the information provided in this application may be shared with other agencies and individuals in the case of a search for the applicant as well as to determine the applicant's eligibility for the program.

\_\_\_\_\_  
Caregiver's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's name

**Applications can be mailed to:**  
Boulder County Sheriff's Office  
Attn: Detective Ali Thompson  
1777 6th Street,  
Boulder, Colorado 80302.