University of Colorado Colorado Springs

HealthCircle Aging Center
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CAREGIVER FAMILY THERAPY: CLIENT DATA FORM

CAREGIVER CHARACTERISTICS

CG#:_____ (for admin only)

CAREGIVER NAME: _____ DATE: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ E-MAIL: _____

DO YOU LIVE IN A RURAL AREA? Y N (Urban areas include: 80903-7, 80909-11, 80915-23)

CURRENT LIVING SITUATION: _____ WITH WHOM DO YOU LIVE? _____

LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (for grant funding): __ __ __ __

DOB: _____ AGE:_____

HIGHEST GRADE IN SCHOOL COMPLETED/ DEGREE OBTAINED: _____

CURRENTLY EMPLOYED? YES NO

CURRENT OCCUPATION (IF RETIRED, LIST FORMER OCCUPATION): _____

ANNUAL INCOME RANGE (for research and grant funding): _____

NUMBER OF PEOPLE SUPPORTED BY INCOME: _____

SOURCE OF INCOME: _____

DISABLED: Y N (If yes, please list disability): _____

USER OF OTHER OLDER AMERICANS ACT SERVICE (SEE ATTACHED FORM): Y N

RELATIONSHIP TO THE PERSON RECEIVING CARE (CARE RECIPIENT): _____

(While we consider the below questions important to offer you the best services possible, responses are optional.)

GENDER: _____

PARTNER STATUS: Divorced Legally Separated Married Domestic Partner Single Widowed

RACE/ETHNICITY: African-American/Black, American Indian, Asian, Hispanic/Latino, Native Hawaiian/Pacific Islander, White, Multiracial

SEXUAL ORIENTATION: _____

SPIRITUALITY/RELIGIOUS AFFILIATION: _____

CARE RECIPIENT CHARACTERISTICS

CARE RECIPIENT NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

DOES THE CARE RECIPIENT LIVE IN A RURAL AREA? Y N

CARE RECIPIENT'S CURRENT LIVING SITUATION: _____

LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (for grant funding): __ __ __ __

DOB: _____ AGE: _____

HIGHEST GRADE IN SCHOOL COMPLETED/ DEGREE OBTAINED: _____

CURRENTLY EMPLOYED? YES NO

CURRENT OCCUPATION (IF RETIRED, LIST FORMER OCCUPATION): _____

ANNUAL INCOME RANGE (for research and grant funding): _____

NUMBER OF PEOPLE SUPPORTED BY INCOME: _____

HOW ARE THE CARE RECIPIENT'S EXPENSES PAID? _____

DISABLED: Y N (If yes, please list disability): _____

USER OF OTHER OLDER AMERICANS ACT SERVICE (SEE ATTACHED FORM): Y N

RELATIONSHIP TO THE PERSON PROVIDING CARE (CAREGIVER): _____

(While we consider the below questions important to offer you the best services possible, responses are optional.)

GENDER: _____

PARTNER STATUS: Divorced Legally Separated Married Domestic Partner Single Widowed

RACE/ETHNICITY: African-American/Black, American Indian, Asian, Hispanic/Latino, Native Hawaiian/Pacific Islander, White, Multiracial

SEXUAL ORIENTATION: _____

SPIRITUALITY/RELIGIOUS AFFILIATION: _____

PLEASE DESCRIBE YOUR MAIN CONCERN(S) ABOUT THE CARE RECIPIENT:

PLEASE DESCRIBE AN AVERAGE DAY WITH THE CARE RECIPIENT: