

Penn State ALS/FTD Caregiver Assessment-R2

Safety

The following questions have been designed to address the unique experiences of those caring for a loved one with ALS and changes in thinking and/or behavior. Your answers will assist the ALS Clinic Team to address the specific needs of you and your loved one. If you'd like to explain any of your responses, you may write additional information in the margin.

Thank you very much,

The ALS Clinic Team

1. Caregiver Name:

2. Patient Name:

3. What is your relationship to the patient?

4. Today's Date

MM DD YYYY
: / /

5. Please let us know if you are concerned about your loved one's SAFETY as a result of the changes in thinking and behavior they have had with their ALS. If your loved one is unable to perform an activity, mark "Does Not Apply." For example, if he or she no longer takes food by mouth, mark "N/A" for numbers 1 and 2 below.

	YES	NO	Does Not Apply
A. Stuffing too much food in mouth and/or choking	<input type="text"/>	<input type="text"/>	<input type="text"/>
B. Not eating enough	<input type="text"/>	<input type="text"/>	<input type="text"/>
C. Cooking/preparing meals (including use of stove, knives, etc.)	<input type="text"/>	<input type="text"/>	<input type="text"/>
D. Driving	<input type="text"/>	<input type="text"/>	<input type="text"/>
E. Risk of Falling	<input type="text"/>	<input type="text"/>	<input type="text"/>
F. Use of tools/power equipment	<input type="text"/>	<input type="text"/>	<input type="text"/>
G. Taking medications as prescribed	<input type="text"/>	<input type="text"/>	<input type="text"/>
H. Ability to be left alone or unsupervised	<input type="text"/>	<input type="text"/>	<input type="text"/>
I. Appropriate use of the internet	<input type="text"/>	<input type="text"/>	<input type="text"/>
J. Appropriate interactions with others	<input type="text"/>	<input type="text"/>	<input type="text"/>
K. Ability to find way home if lost	<input type="text"/>	<input type="text"/>	<input type="text"/>
L. Wandering at night	<input type="text"/>	<input type="text"/>	<input type="text"/>

M. Please list other safety concerns you have

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Financial & Legal Matters

6. Are you concerned with your loved one's ability to manage finances? (If YES, answer #7 below)

YES

NO

7. If you answered "YES" to question #6:

Please indicate which aspects of financial management are of concern:

	YES	NO
A. Excessive spending	<input type="checkbox"/>	<input type="checkbox"/>
B. Opening new accounts	<input type="checkbox"/>	<input type="checkbox"/>
C. Purchasing from solicitors	<input type="checkbox"/>	<input type="checkbox"/>
D. Excessive gambling	<input type="checkbox"/>	<input type="checkbox"/>
E. Giving money away	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

8. Has your loved one completed the following legal documents?

	YES	NO	I DON'T KNOW
Power of Attorney (POA) for financial matters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Power of Attorney (POA) for health care matters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advance Directive/Living Will	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. If YES to #8, has the Advance Directive/Living Will been shared with:

	YES	NO	I DON'T KNOW
The patient's family doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The ALS Team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

5

6

Caregiver Well-being

10. Have you noticed changes in your loved one's behavior or personality?

YES

NO

If YES, Please describe the changes you've noticed.

11. If YES to #10, have your loved one's changes in behavior caused you to feel:

	Almost never	Sometimes	Very often
Embarrassed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frustrated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angry?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other feelings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please explain:

12. Do you currently have trouble sleeping?

No, not at all

A little bit

Very much so

Please explain:

13. Overall, how overwhelmed do you feel in caring for your loved one?

	Not at all	A little	Moderately	Quite a bit	Extremely
I feel...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please provide any details you think would help us to understand your concerns related to ALS and changes in thinking and/or behavior.