

# **Adult Questionnaire**

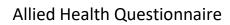
|  | Yes | No |
|--|-----|----|
| Does the participant identify as:  |     |    |
| Aboriginal   |     |    |
| Torres Strait Islander   |     |    |
| South Islander   |     |    |
| Is the participant demonstrating a loss of skills, or a regression of skills?  |     |    |
| Does the participant have a neurological or progressive condition<br>(Parkinson's Disease, Multiple sclerosis, Motor Neuron Disease, Stroke,<br>Brain injury)? |     |    |
| Has the participant gained or lost weight recently?  |     |    |
| Has the participant been admitted to hospital in the last 12 months?   |     |    |

# Psychology/ Behaviour Therapist/ Counselling

# *"Life Choice is not a crisis service, if you are experiencing a crisis and are at risk please call Lifeline on 13 11 14 or emergency services on 000 if required."*

Are there any previous or current concerns regarding the participant and the following?

|  | Yes | No |
|--|-----|----|
| Risk of harm to self and/or others   |     |    |
| Domestic and family violence   |     |    |
| Are there any court orders/ interventions in place (parenting, domestic violence)? |     |    |





## Speech Therapy:

|  | Yes | No |
|--|-----|----|
| Does the participant have a way to communicate their basic needs?        |     |    |
| How does the participant primarily communicate?                          |     |    |
| Sounds   |     |    |
| <ul> <li>Body movements/ gestures/ Facial expressions</li> </ul>         |     |    |
| Pictures   |     |    |
| • Signs  |     |    |
| Written words  |     |    |
| AAC device   |     |    |
| <ul> <li>Shorter phrases (1-4 words)</li> </ul>                          |     |    |
| <ul> <li>Longer phrases/ full sentences</li> </ul>                       |     |    |
| Is the participant stuttering? Has this been happening for more than 3   |     |    |
| months?  |     |    |
| Is the participant eating less than 30 foods?                            |     |    |
| Does it take 30 minutes or longer to feed this participant/for this      |     |    |
| participant to eat?  |     |    |
| Have you noticed any of the following during eating or drinking:         |     |    |
| Choking  |     |    |
| Gagging  |     |    |
| Coughing   |     |    |
| Gurgly voice   |     |    |
| Distress for the participant and/or caregiver                            |     |    |
| Has the participant had any recent chest infections or pneumonias in the |     |    |
| past 3-6 months?   |     |    |

## Comments:



## **Exercise Physiology**

|   | Yes | No |
|---|-----|----|
| Does the participant have any activity of daily living that they            |     |    |
| have difficulty doing due to pain, weakness or poor coordination? Would     |     |    |
| the participant like to improve their function of these tasks?              |     |    |
| Does the participant have a chronic disease diagnosis such as type 2        |     |    |
| diabetes, cardiovascular disease, respiratory disease (chronic bronchitis,  |     |    |
| emphysema) and/or osteopenia or osteoporosis?                               |     |    |
| Does the participant have any chronic joint, muscle, tendon or ligament     |     |    |
| diagnosis that impacts on their quality of life or affects their ability to |     |    |
| complete functional tasks?  |     |    |
| Does the participant have difficulty with balance and coordination? Has     |     |    |
| the participant had a fall in the last 12 months?                           |     |    |

## Comments:

# **Physiotherapy**

|  | Yes | No |
|--|-----|----|
| Does the participant urgently need a walking aid/ equipment to enable them to walk/ move/ transfer safely?                 |     |    |
| Has the participant had a significant loss of mobility/ function over the last 2 months requiring more help to move/ walk? |     |    |
| Does the participant regularly have falls? Including getting in and out of bed?  |     |    |
| Does the participant complain of undiagnosed pain/ injury?   |     |    |
| Does the participant complain of acute pain?   |     |    |

## Comments:



## **Occupational Therapy**

|   | Yes | No |
|---|-----|----|
| Does the participant require the urgent need of equipment (electric   |     |    |
| bed/chair, wheelchair) or assistive technology to promote their safety?                                       |     |    |
| Is the participant experiencing a cognitive decline in the last 12 months? (memory loss, increased confusion) |     |    |
|   |     |    |
| Is the participant at high risk/ already experiencing pressure injuries? (bed sores, pressure areas)          |     |    |
| Is the participant partaking in behaviours that are putting themselves and others at risk?                    |     |    |

## Comments:

## **Dietetics (nutrition)**

|  | Yes | No |
|--|-----|----|
| Does the participant require assistance with education or decision making    |     |    |
| around cooking, food shopping, meal planning?                                |     |    |
| Does the participant live with a chronic disease that is impacting their     |     |    |
| health, functioning or independence?   |     |    |
| Is the participant experiencing bowel concerns (e.g. constipation, diarrhea, |     |    |
| loss of appetite)?   |     |    |
| Is the participant experiencing fatigue or tiredness that is impacting their |     |    |
| functional ability / ability to use required equipment?                      |     |    |
| Is the participant receiving enteral nutrition or using nutritional          |     |    |
| supplements?   |     |    |
| Does the participant require support around healthy eating?                  |     |    |

#### Comments: