JFSCOMPASS

Providing medical care for individuals with dementia
and guiding families through their journey

Memory Café Intake Form

Please answer the questions below as they pertain to the participant who will be attending Memory Café.

Participant Name: _____ **Date of Birth:** _____

CONTACT INFORMATION

Your Name: _____ Relationship to Participant: _____

Your Phone Number: _____ Today's Date: _____

Emergency Contact Name: _____ Phone: _____

MEDICAL INFORMATION

1. Does the participant have any medical conditions that we should be aware of? ☐ Yes ☐ No

   If yes, please explain: _____

   _____

2. Does the participant have any severe or life-threatening allergies? ☐ Yes ☐ No

   If yes, please explain: _____

COMMUNICATION AND MOBILITY

3. Does the participant prefer to use their left or right hand to complete tasks?

   ☐ Left Hand ☐ Right Hand

4. Does the participant have…

   a. a hearing impairment? ☐ Yes ☐ No

   b. a visual impairment? ☐ Yes ☐ No

   c. difficulty verbalizing their needs? ☐ Yes ☐ No

5. Does the participant use any devices, e.g., cane, walker, or wheelchair to get around?

   ☐ YES ☐ NO

PERSONAL CARE

6. Does your person require assistance to go to the bathroom? ☐ YES ☐ NO

UNIQUE QUALITIES & INTERESTS

1. What name does the participant like to be called? _____
2. What types of jobs/achievements have they had in their life?

   _____

   _____
3. What makes the participant unique? _____

   _____
4. What is the participant's favorite…
   a. food? _____
   b. topic to talk about? _____
   c. activity? _____
5. When is the participant happiest? _____

   _____
6. Is there anything that makes them feel worried or upset?

   _____

   _____
7. When the participant is upset, is there anything that helps to calm them?

   _____

   _____
8. Is there anything else we should know about the participant?

   _____

   _____

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