Office of the Sheriff
Michael D. Andrews, Sheriff

| Frequency #: | ID #: | Client #: |
|---|---|---|

# Project Lifesaver Client Profile

| Client's Name: | | Nickname: |
|---|---|---|
| Address: | City: | Zip: |
| County: | Phone #: | DOB: |

| Name of Spouse/Parent: | Living/Deceased: |
|---|---|
| Medical Diagnosis of Brain Disorder: (*Attach report, letter, etc. from doctor to document diagnosis)* | |
| Has client wandered away from home/caregiver in the past? Yes or No | How many times? |
| If yes: where, when, time of day, who found client and where, how long he/she was lost, etc.: | |

| Primary Caregiver Name/Relationship to Client: | | |
|---|---|---|
| Address: | City: | Zip: |
| Phone #: | | |

| Secondary Caregiver Name/Relationship to Client: | | |
|---|---|---|
| Address: | City: | Zip: |
| Phone #: | | |

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| Other persons to contact (family/friends/etc): | | |
| --- | --- | --- |
| Address: | City: | Zip: |
| Phone #: | | |

# Physical Description

| Sex: | |
| --- | --- |
| Race/Nationality: | |
| Complexion: | |
| Build: | |
| Height: | |
| Weight: | |
| Eye Color: | |
| Hair Color: | |
| Hair Style: | |
| Sideburns: | |
| Mustache/Beard: | |
| False Teeth/Braces: | |
| Cane/Walker: | |
| Scars/Marks/Tattoos (location): | |
| General Appearance: | |
| Client Verbal: Yes or No | What language used (signs/gestures/pictures): |

| Glasses/Contacts: | Vision without eyewear (good/poor/fair): |
|---|---|
| Hearing Aid: | Hearing without aid (good/poor/fair): |

# Health & Psychological Condition

| Have any physical handicaps? Yes or No<br>Explain: | |
|---|---|
| Have any medical problems? Yes or No<br>Explain: | |
| List all Medications: | |
| Suffer any consequences if medications are not taken? | |
| Primary Care Physician: | Phone #: |
| Have any psychological problems? | |
| Remain oriented to time and people? | |
| Recognize familiar persons and faces? | |
| Tends to re-live past events in his/her life? | |
| Sometimes dressed improperly? | |
| Remember his/her own name and the names of spouse, children, siblings, etc.? | |

| Suffer from frequent personality and emotional changes? |
| --- |
| Suffer from delusions? |
| Additional Information: |

## Personality/Habits

| Does Client carry certain items with them for comfort?  If yes, please describe in detail: | |
| --- | --- |
| Wear jewelry (Medical Alert/ring/watch?) | |
| Use tobacco? | Use alcohol? |
| Hobbies/Interests: | |
| Prefer to be alone? | Quiet? |
| Religious Functions?  Where? | |
| Favorite Person?  Relationship? | |
| Fear Animals/Dark/Noises/People/Water/Other? | |

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| Explain reactions to fears: |
| --- |
| Things to avoid: |
| Have certain reactions when hurt (Over/under sensitive/hide?) |
| Talk to strangers/pretend to know strangers? |
| Easily frustrated?  What should be avoided? |
| What things does Client like/would be attracted to that could aid in a search? |

## Experiences

| How long has client lived at present address? |
| --- |
| Previous address/how long lived there: |
| Where did Client live most of their life? |
| Past Employers/Occupation: |
| Scouts/Wilderness Training: |
| Overnight Camping: |

| First Aid Training: |
|---|
| Military Service: |
| Sports/What time & age: |
| Like to go to sporting events/watch on TV? |
| Other: |

# **Timeline**

| Year | |
|---|---|
| | Born in (city/state) |
| | Elementary School (name,city,state) |
| | Middle School (name, city, state) |
| | High School (name, city, state) |
| | College (name, city, state) |
| | Job (name, occupation, city, state) |
| | Married (name) |
| | Child (name) |
| | Child (name) |
| | Grandchild (name) |

| | |
|---|---|
| | Grandchild (name) |
| | Retired (name, occupation, city, state) |
| | Diagnosed |
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|---|
| Date transmitter placed on client: |
| Person placing transmitter: |
| Title & agency/organization of person: |