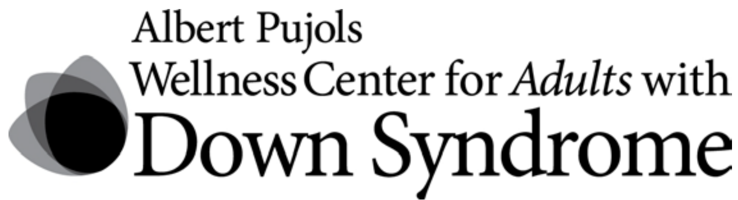

Welcome to the Albert Pujols Wellness Center for Adults with Down Syndrome. A Medical, Social and Nutritional History questionnaire is enclosed in this package. All questions refer to the adolescent or adult with Down syndrome. If you do not understand a question, leave it blank and we will discuss it the day of the visit.

Please complete these forms and mail back to us in the envelope provided *at least 7 days prior* to your visit. You may also fax the information to us at 314-576-2370 or send via email to ADS.WellnessCenter@stlukes-stl.com.

If possible, please bring:

- ***Legal guardianship papers, if applicable.***
- Physician report and lab results from most recent exam
- Immunization Records
- Previous thyroid blood test results
- Previous echocardiogram reports
- Any information relating to a specific problem or concern you would like us to address
- Current Medicare, Medicaid or other insurance card

Your visit to the clinic will last approximately two hours and includes a medical, social, and nutritional evaluation. A familiar family or staff member must accompany each patient to assist in answering questions.

We are located in **The Mr. And Mrs. Theodore P. Desloge, Jr. Outpatient Center**, across the street from St. Luke's Hospital. You will now be considered a patient of St. Luke's Hospital under the umbrella of the *Albert Pujols Wellness Center for Adults with Down Syndrome*. Please contact us if you have questions before your appointment. Our phone number is 314.576.2300.

Client Name: ____

Appointment: ____

Albert Pujols Wellness Center
For Adults with Down Syndrome
Client Registration Form

Please fill in every blank – Please print

Client Information:

Full Legal Name: ____

Name Preference (nickname):____________________________________

Address:

____

City: ______________________ State: _________ Zip Code: _______________

Social Security Number: _________________ Date of Birth: __________________

Gender: **Male Female** State of Birth: ________ Mother's Maiden Name: ___________

Race: (circle one) Caucasian African American Hispanic Asian Multi-Racial Native American Indian Native Hawaiian Other

Primary Contact (Legal Next of Kin or Guardian):

Full Legal Name: ____

Relationship: ____________________ Legal Guardian? **YES** **NO**

Main #: ____________________ Secondary # ______________________

Date of Birth: __________________ Social Security #: __________________

Address: ____

Email Address: ____

Additional contact:

Full Legal Name: ____

Relationship: ____________________ Legal Guardian? **YES** **NO**

Main #: ____________________ Secondary # ______________________

Date of Birth: __________________ Social Security #: __________________

Address: ____

Email Address: ____

Insurance Information:

Primary Insurance Company Name: ____

Social Security # of the Insured: _________________________ Insured's Employer: ______________________

Insured's Relationship to Client: ____

Policy #/ Certification #/ID _______________________________ Group#_________________________________

Benefit/Eligibility Phone #:____________________________________

Secondary Insurance Company Name: ____

Social Security # of the Insured: _________________________ Insured's Employer: ______________________

Insured's Relationship to Client: ____

Policy #/ Certification #/ID _______________________________ Group#_________________________________

Benefit/Eligibility Phone #:____________________________________

Name of Primary Care Physician (PCP): ____

Address: ____

City: _________________________________State: ___________________Zip Code: _______________________

Telephone #: ________________________________

Specialty Physicians

Physician Name	Specialty	Office Phone Number

Albert Pujols Wellness Center
for Adults with Down Syndrome
Health Questionnaire

All Questions Refer to the Person with Down Syndrome (DS).

Name ______________________________________ Date of Birth: ____________ Age: ________

Person filling out the form/relationship: ____

Do you have any concerns regarding the health, behavior or memory of the person with DS? Please write in the space below or on another sheet of paper, if necessary.

____

____

____

____

REVIEW OF SYSTEMS

NEUROLOGICAL	**YES**	**NO**
Has the person with DS had memory problems?	______	______
Had any change in their usual behavior?	______	______
Had any change in their interest in life/activities?	______	______
Seemed sad or withdrawn?	______	______
Is the person with DS able to learn to do new things?	______	______
Have they stopped being able to do things they used to do?	______	______
Have they ever had seizures, fits or spasms?	______	______
Are you concerned about how the person with DS is acting or feeling?	______	______
Have they ever fainted with exercise?	______	______

If yes, please describe.

____

____

ENDOCRINE	**YES**	**NO**
Does the person with DS have a thyroid problem?		
If yes, is it underactive or overactive?	______________	
When was the last Thyroid test?	______________	
Have they ever been diagnosed with diabetes?	______	______
Have they been drinking more liquids lately?	______	______
Have they recently been urinating more?	______	______

GI (Gastrointestinal)	**YES**	**NO**
Does the person with DS have difficulty with bowel movements?		
If yes, in what way and how often. ____________________________		
Does the person have accidents with urine or stool?	______	______
Do they ever have pain in their abdomen or stomach?	______	______

MS (Musculoskeletal	**YES**	**NO**

Does the person with DS have difficulty walking?	______	______
Do they fall frequently?	______	______
Do they use any assistive walking devices?	______	______
Do they suffer any joint pain or arthritis?	______	______
Has the person with DS ever had neck x-rays?	____________	
If yes, when? Were there any problems found on the x-rays?	____________	

HEENT	**YES**	**NO**
Does the person with DS wear glasses or contacts	______	______
Do they have any vision problems?	______	______
Does the person with DS use hearing aids?	______	______
Do they have any hearing problems/loss?	______	______
Is there a problem with ear infections? Wax build-up?	______	______
Does the person have a frequent runny nose?	______	______
Do they have sinus problems?	______	______

RESPIRATORY	**YES**	**NO**
Does the person with DS get pneumonia often?	______	______
Do they have a persistent cough?	______	______
Do they get frequent bronchitis?	______	______
Have they ever had asthma?	______	______
Do they have difficulty breathing with exercise?	______	______

SKIN	**YES**	**NO**
Does the person with DS have dry skin?	______	______
Do they have any issues with their toenails?	______	______
Do they have any other skin conditions?	______	______

If yes, please describe.

Products used for skin problems:

SLEEP	**YES**	**NO**
Does the person with DS seem tired often?	______	______
Are there any problems sleeping?	______	______
Does the person with DS snore?	______	______
Do they ever stop breathing for a short while when asleep?	______	______
Have they ever had a sleep study?	______	______
If yes, when.	____________	

CARDIOVASCULAR	**YES**	**NO**
Has the person with DS ever had high blood pressure?	______	______
Have they ever been told they have a heart murmur?	______	______
Do they have high cholesterol?	______	______
When was their last cholesterol test?	____________	
Have they been told they have a heart condition?	______	______
Have they been diagnosed with heart disease?	______	______
Do they have swelling in the ankles or hands?	______	______
Do they have varicose veins?	______	______
Do they ever have chest pain with exercise?	______	______
Have they ever been told not to exercise due to a heart condition?	______	______

MOUTH | | YES | NO
---|---|---
Does the person with DS have any teeth or gum problems? | ____ | ____
Do they wear dentures? | ____ | ____
Have they had any other dental work? | ____ | ____
If yes, please explain. | |

____

Do they brush their teeth daily? ____ ____
Floss regularly? ____ ____
Do they see a dentist regularly?
If yes, how often? ____________________
Have they ever been asked to take an anti-biotic when going to the dentist? ____ ____

GENITAL

For women:

Age periods began ____________________
Are they regular? ____________________
Is she sexually active? ____________________
Is she on birth control? ____________________
Has she had a PAP smear? ____________________
If yes, date of last PAP: ____________________
Has her PAP ever been abnormal? ____________________
Has she had a mammogram? ____________________
If yes, date of last mammogram: ____________________
Has her mammogram ever been abnormal? ____________________
Name of OB/GYN ____________________

For men: **YES** **NO**

Is the man with DS sexually active? ____ ____
Does he have a hernia? ____ ____
Does he have an undescended testicle? ____ ____

EATING, DRINKING, WEIGHT AND DIET **YES** **NO**

Is the person with DS having trouble eating food or drinking liquids? ____ ____
Do they have trouble swallowing solid foods or liquids? ____ ____
Do they have trouble choking/gagging on solid foods or drinks? ____ ____
Do they have any special dietary needs? ____ ____
Has the person been tested for celiac disease? (sprue or wheat/gluten intolerance)
If so, what were the results? ____________________
Has the person with DS had a recent weight loss or weight gain?
How much weight loss or gain? ____________
Over what length of time? ____________
Are there concerns with texture of food? ____ ____
Does the person with DS refuse to eat any types of food? ____ ____
Does the person with DS follow any specific type of diet? ____ ____
If yes, please describe.

____

General

Past Surgeries/Year

Any other medical concerns

Family Medical History

Please check the box for everyone in the family of the person with DS who has had any of the following health problems:

CONDITION	MOTHER	FATHER	SIBLING	OTHER
Down syndrome	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Dementia/Alzheimer's	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer/Leukemia	☐	☐	☐	☐
Depression/Mental Illness	☐	☐	☐	☐
Other:_______________	☐	☐	☐	☐

Allergies

- ☐ Food:____
- ☐ Drug:____
- ☐ Animals:____
- ☐ Seasonal:____

Lifestyle

- Does the person with DS smoke? **YES** **NO**
  - If yes, how much? ____________________
  - If quit, when? ____________________

- Does the person with DS drink alcohol? **YES** **NO**
  - If yes, how much? ____________________
  - If quit, when? ____________________

- Does the person with DS use recreational/illegal drugs? **YES** **NO**
  - If yes, how much? ____________________
  - If quit, when? ____________________

- Does the person with DS participate in regular exercise or physical activities? **YES** **NO**
  - If yes, what types, how long, and how often? Describe below

____

____

____

____

- Does the person with DS attend school? **YES** **NO**
  - If yes, what is the name of the school? ____________________

- Does the person with DS attend a day program? **YES** **NO**
  - If yes, what is the name of the program? ____________________

- Does the person with DS have a job? **YES** **NO**
  - If yes, what is the name of their employer? ____________________

- Where does the person with DS live?

  - ☐ Family home
  - ☐ Own home
  - ☐ Group home
    - If in a group home, how many people live there? ____________________
  - ☐ Independent living facility

Social Information

1. Parents

Name	Age	Occupation

2. Siblings

Name	Age	Occupation

3. Community Access Providers/Case Managers/Support Staff

Name	Employed by	Address

Albert Pujols Wellness Center
for Adults with Down Syndrome
Report Distribution Schedule

Client Name: ____ Date: _______________________

Three to four weeks after the initial clinic visit to the Albert Pujols Wellness Center for Adults with Down Syndrome, a written summary is sent that includes a report of all the evaluations and recommendations. The signature below authorizes us to send the report. Please indicate below to who you want the report to be sent.

Client's Signature, if self guardian: ____

Or

Signature of Guardian or Empowered Staff: ____

I hereby authorize and request copies of the report to be sent to:

Family/Patient: Name and Address

____

____

____

____

Service Agency/Residential Facility: Name and Address

____

____

____

____

Medication/Immunization List

Name: ____DOB:__________________

Diagnoses: ____

____

Pharmacy: ____________________________________Phone #______________________

MEDICATION	DOSE	FREQUENCY	COMMENTS

IMMUNIZATIONS

	YES	NO
Has the person with DS had two Hepatitis A vaccines?	______	______
Has the person with DS had three Hepatitis B vaccines?	______	______
When was the last DPT or tetanus shot?	______________	
Have they had chicken pox?	______	______
Have they had the chicken pox vaccine?	______	______
Do they get the flu vaccine annually?	______	______
Have they had the pneumonia vaccine?	______	______
Have they had the HPV vaccine?	______	______

Psychosocial Questionnaire

These questions pertain to information related to the individual with Down syndrome's social, family, financial, and vocational situation. Please complete the questions as thoroughly as possible. If you feel uncomfortable answering any of these questions, or don't understand the question, leave it blank and we can discuss it the day of your appointment.

Demographic Information

Name: ______________________________________ Date of Birth: _____________

Does the person with Down syndrome have any religious or cultural practices that we need to be aware of? If so please indicate below.
____

Are they currently receiving any in-home services (i.e. home health, chore worker, personal care attendant)?
____

Please circle any government programs they are currently receiving:

Medicare **Medicaid** **Medicaid Waiver program**

Please specify:__________________________

Primary source of income:

Salary **SSI** **SSDI**

The person with Down syndrome's support group consists of (circle all that apply):

Parents **Siblings** **Friends**

Other:
____

Educational history

Age formal education began: _________________

Highest grade completed: ___________________

Type of class room: **Regular** **Special Ed** **Other**

Vocational Training received post high school: **YES** **NO**

Current Level of Functioning

Is the person with DS independent in all their activities of daily living? **YES** **NO**

If no, please indicate what they need assistance with and to what extent:

____

____

____

Communication skills

- ☐ Can communicate own needs
- ☐ Sometimes has trouble expressing own needs
- ☐ Becomes frustrated when trying to expressing own needs
- ☐ Non verbal unable to express own needs

Socialization skills

Makes friends easily? **YES** **NO**

Likes to talk to others? **YES** **NO**

Do they ever have trouble getting along with others? **YES** **NO**

If yes, please describe:

____

Please list any barriers they have accessing community or activities or programs:

____

____

Safety Concerns

Please list any safety concerns you have for the person with Down syndrome (i.e. sexual abuse, con artist, money, physical abuse):

____

____

Do the safety concerns listed above ever interfere with their independence in accessing programs or services in the community?

____

____

Nutritional Assessment

First name_______________________________ Last Name________________________________

Date of Birth___________________ Gender __________

Residence: ____ private home ____ group housing

Primary caregiver/contact regarding this program:
Name ____
Phone ____

Meal Information:
Number of meals daily: ______________
Choose one of the following:
Foods are portioned____
If portioned, are second's available_____
Foods are served "family style" ____
Foods are served "cafeteria style" ____
Comments____
Choose one of the following:
Client has some input into foods served___
Client has total control of foods they choose___
Client has no input into foods served___
Comments____
Choose one of the following:
Client has access to food between meal times___
Client has no access to food between meal times___
Comments____
Choose one of the following:
Client has choice to have meals from restaurant/fast foods___
Client has meals from restaurants/fast food how many times monthly_______
Comments____

Food preferences:

Breakfast Foods:
____
____
____

Lunch/Dinner Foods:
____
____
____

Snack Foods:

____

____

____

Beverages:

____

____

____

Diet History:
Please provide a typical diet for the client for a two-day period.

Day 1

Breakfast

____

____

Lunch

____

____

Dinner

____

____

Snacks____

Day 2

Breakfast

____

____

Lunch

____

____

Dinner

____

____

Snacks____

Comments

____

____

____