



Albert Pujols
Wellness Center for *Adults* with
Down Syndrome

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia/Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
