



Project Lifesaver:
Travis County

Frequency: _____

Client Number: _____

Project Lifesaver: Travis County Client Profile

Personal Data Questionnaire

Resident: _____

Address: _____

City/State: _____ Zip: _____

Phone: _____

Date Transmitter Placed: _____

Facility/Organization: _____

Address: _____

Phone: _____

PL Servicer filling out this form: _____

PL Servicer that places transmitter on: _____

This form is designed for Custodial Care Givers to provide, in advance, certain information that will be useful to Search Teams, should the need arise. Providing the information in advance of the need will allow Search Management Personnel the necessary information to establish a more effective search response.

Resident's Personal Data

Birthdate: _____ Sex: Male/Female Race: _____
Nickname(s): _____
Most recent address: _____
Most recent place of work: _____
Most recent occupation: _____
Name of Spouse: _____ Living/deceased (circle one)

Family/Friend Information

Other persons the resident might contact (family, friends, etc.)

Name: : _____ Phone: _____

Address: _____

Relationship to client: _____

Name: _____ Phone _____

Address: _____

Relationship to client: _____

Responsible Party Paying for client _____

Diagnosis: _____

Physical Description

Height ____ft. ____in. Weight ____lbs. Build ____

Hair color _____ Hair Style _____ Eye Color _____

Complexion _____ Beard Yes/No Sideburns Yes/No

Mustache Yes/No Balding Yes/No False Teeth Yes/No

Shape of facial features: Round/Square/Oval/Other _____

Distinguishing marks, scars, tattoos, etc. Describe _____

General Appearance _____

What language does Resident best understand? _____

Spoken word only Yes/No or Written/Spoken

Does Resident wear glasses? Yes/No Contacts? Yes/No Sunglasses Yes/No.

If yes to any of the above, what style: _____

What degree of vision does he/she have without corrective eyewear?

None/Poor/Fair (circle one)

Personal Data Questionnaire

Does Resident wear a hearing aid _____ What style? _____

If yes, what type of hearing without aid? None/Poor/Fair (circle one)

Health/Psychological Condition

Any known physical handicaps? _____

(Describe please) _____

Any known medical problems? _____

(Describe please) _____

Medications taken regularly? _____

List any medication using correct name of drug and dosage being taken

- Medication _____ Dosage _____ / day
- Medication _____ Dosage _____ / day
- Medication _____ Dosage _____ / day
- Medication _____ Dosage _____ / day
- Medication _____ Dosage _____ / day
- Medication _____ Dosage _____ / day

Consequences of NOT taking medications?

Attending Physician _____ Phone No _____

Any Psychological Problems? Yes/No

Nature: _____

PROJECT LIFESAVER
 LOST SUBJECT PROFILE

INCD. NAME	DATE	TIME	INCD. CMDR.
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PERSONAL

NAME	NICKNAME	AGE	RACE	SEX
HOME ADDRESS		CITY	STATE	
NAMES OF FAMILY OR NEAREST RELATIVES				

PHYSICAL DESCRIPTION

HEIGHT	WEIGHT	COMPLEXION	HAIR COLOR
HAIR STYLE		FACIAL HAIR	EYE COLOR
DISTINGUISHING MARKS			

CLOTHING

SHIRT	<input type="checkbox"/>	STYLE & COLOR	NOTES
DRESS	<input type="checkbox"/>	STYLE & COLOR	NOTES
SWEATER	<input type="checkbox"/>	STYLE & COLOR	NOTES
PANTS	<input type="checkbox"/>	STYLE & COLOR	NOTES
COAT	<input type="checkbox"/>	STYLE & COLOR	NOTES
HAT	<input type="checkbox"/>	STYLE & COLOR	NOTES
SHOES	<input type="checkbox"/>	STYLE & COLOR	NOTES
SHOES SIZE	SOLE STYLE		TREAD PATTERN

PERSONAL ITEMS IN POSSESSION

ADDITIONAL NOTES/ PICTURE

WALLET/PURSE	<input type="checkbox"/>
JEWELRY	<input type="checkbox"/>
TOBACCO	<input type="checkbox"/>
CANDY/GUM	<input type="checkbox"/>
EYE GLASSES	<input type="checkbox"/>
KNIFE/TOOLS	<input type="checkbox"/>
CANE STICK	<input type="checkbox"/>
OTHER	<input type="checkbox"/>

PHYSICAL/MENTAL CONDITION

PHYSICAL	
MENTAL	
MEDICATION	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>
ILLICIT DRUGS	<input type="checkbox"/>

If Alzheimer's disease has been diagnosed, Answer the following:

1. Does the Resident remain oriented to Time and Person? Yes/No
Explain

2. Does the Resident recognize familiar persons and faces? Yes/No
Explain

3. Can the Resident travel to familiar locations? Yes/No
Explain

4. Does the Resident have deceased knowledge of current events or tend to re-live events in his/her life? Yes/No
Explain

5. Does the Resident sometimes clothe himself/herself improperly? Yes/No
Example: Putting shoes on the wrong feet, adding underwear over clothing?
Explain if necessary

6. Does the Resident remember his/her own name and the names of spouse and or children? Yes/No
Explain

7. Are the Resident's sleep patterns frequently? Yes/No
Explain

8. Does the Resident suffer from frequent personality and emotional changes? Yes/No
Explain

9. Does the Resident suffer from delusions (See Imaginary Visitors, Talk to his/her own reflection in the mirror, Imagine that their spouse is an imposter, etc?) Yes/NO
Explain _____

10. How good is the Resident's communication ability?
None/Poor/Fair/Good/Excellent
(circle one please)

Personal Articles Normally Carried by the Resident:

Tobacco Products: Yes/No Type _____ Brand _____

Candy/Gum: Yes/No Brand _____

Matches: Yes/No Lighter: Yes/No Type _____

Food Items: _____

Facial tissue or other pocket/purse items: _____

Approximate Amount of Cash on Hand? \$ _____

Where Normally Carried _____

Handbag, Purse or Wallet: _____

Description _____ Type _____ Color _____

Jewelry (Please describe) _____

Watch? _____ Type _____ Color _____

Description _____

Equipment

Cane/Walker or _____ Hunting/Fishing, Etc _____
(circle one or describe)

Other: _____

Experience

Familiar with area? Yes/No How recently _____

Days/Months/Years

If not local, what other areas are known to Resident? _____

Taken outdoor classes? Yes/No

Where? _____ When? _____

Taken first-aid training? Yes/No
Where? _____
When? _____

Involved in Scouting? Yes/No Explain _____
Military Experience? Yes/No
Where _____ When _____

Recreational Outdoor Experience? Yes/No _____

Overnight Camping Experience? Yes/No _____

Ever been lost before? Yes/No
Where _____
When _____
Time of Day _____

Located by searchers or walk out by himself/herself? _____

Location found: _____

Actions taken: _____

Ever go out alone? Yes/No stay on trails? Yes/No

General Athletic Interest/Abilities _____

Personality Habits

Smoke? Yes/No How often _____ what _____ Brand _____

Drink Alcohol? Yes/No What Type? _____ Brand _____

Use Illicit Drugs? Yes/No How often _____ Type _____

Hobbies/Interests

Outgoing or Quiet; Likes Groups or being alone?

Evidence of Leadership Yes/No

Explain _____

Ever been in trouble with the law? Yes/NO

What _____

Religious? Yes/No

What faith _____

What does Resident value most?

Which family member is resident closest to? _____
Relationship _____

Where was Resident born and raised?

Has Resident received any letter recently? Yes/No
From Whom _____

Is resident afraid of Dogs? Yes/No

The dark? Yes/No

Noises? Yes/No (circle one beside each)

Horses? Yes/No People? Yes/No Other (explain)

What actions taken hurt? (Cry, shout, etc.?)

Will Resident talk to strangers? Yes/No (circle one)

Is the Resident DANGEROUS to him/herself or others? Yes/No (circle one)