Needs Assessment Questionnaire for a Medical Alert

1. Do you live alone?
   ____ Yes ____ No

2. (If the answer to #1 is "no.") Are there periods of the day or week when your caregiver is away, and you are alone?
   ____ Yes ____ No

3. Have you fallen inside or outside your residence at least one time during the past 3 years?
   ____ Yes ____ No

4. Are there times when you feel weak or dizzy?
   ____ Yes ____ No

5. Are you worried that you may fall and not be able to call for help?
   ____ Yes ____ No

6. Do you worry about taking a shower or bath alone? (falling, getting ill, etc.)
   ____ Yes ____ No

7. Do you have one or more of these ailments?

   - Arthritis
   - Chronic Obstructive Pulmonary Disease (COPD)
   - Congestive Heart Failure (CHF)
   - Diabetes
   - Hypertension or high blood pressure
   - Low vision or visually impaired
   - Osteoporosis
   - Stroke

   ____ Yes ____ Yes, more than 1 ____ No

8. Are you concerned that you may have a reaction to medication and not be able to get help? (example: insulin)
   ____ Yes ____ No

9. Were you hospitalized or taken to the emergency room during the past 2 years?
   ____ Yes ____ No

10. Do you use a cane, walker, wheelchair, stair climber, or other device to help you balance or walk?
    ____ Yes ____ No

11. Are you afraid that someone may hurt you physically or break into your home?
    ____ Yes ____ No

12. Do you feel unsafe in your neighborhood?
    ____ Yes ____ No

Total: ____ Yes ____ No

For more information, contact:
My Guardian Angel
413-624-0200
800-624-0200
When seconds count