

# LIFESTYLE HISTORY AND HABITS

## OF THE RESIDENT

This form will enable us to get to know the resident better, so that we can personalize care and interventions as much as possible, based on their history and home habits. Feel free to answer any questions you're comfortable with. A member of our team can accompany you, if necessary. This form will be treated as confidential.

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **FILE NUMBER:** \_\_\_\_\_ (For administrative use)

### GENERAL INFORMATION ABOUT THE PERSON

What does the person prefer to be called:

**Civil status:**      Single      Married      Widowed      Separated      Divorced      Common-law spouse

**Spouse's name:** \_\_\_\_\_ **Since (number of years):**      year(s)

**Place of birth:** \_\_\_\_\_ **Family rank:** \_\_\_\_\_

If born outside Canada, when did the person arrive in Quebec:

**Number of brothers:** \_\_\_\_\_ **Number of sisters:** \_\_\_\_\_ **Political interest:** \_\_\_\_\_

**Can read:**    Yes    No      **Can write:**    Yes    No      **Right-handed**      **Left-handed**      **Education:** \_\_\_\_\_

**Languages spoken:** \_\_\_\_\_ **Other languages known:** \_\_\_\_\_

**Does the person have children:**    Yes    No      **How many:** \_\_\_\_\_

Children's names	Rank	Gender		Recognizes		Nearness and connection	Living	
		F	M	Yes	No		Yes	No

### SIGNIFICANT PEOPLE

Name	Relationship

### ASPECTS OF EMOTIONAL LIFE

**Heterosexual**      **Homosexual**      **Bisexual**      **Prefer not to answer**      **Other**

**Specific need for privacy:**    Yes    No      **If yes, what:** \_\_\_\_\_

### SIGNIFICANT OCCUPATIONS (FUNCTION, WORK SCHEDULE)

Between 15 and 35 years old	
Between 35 and 55 years old	
From 55 years old to now	

## PERSONALITY

**BEFORE** the onset of health problems, what was the person's character (e.g., sociable, quiet, solitary, authoritarian, determined, optimistic, anxious, gentle, hard-working, coquettish, proud, etc.):

Now, what do you observe in the person:

A type of emotional reaction to unusual situations that has been known for a long time (e.g., excessive joy or embarrassment, phobia, mania, feverishness, impulsiveness, way of expressing oneself, etc.):

This calms the person, does them good, and makes them feel better in the above situations:

Other information deemed important and relevant to getting to know the person better, or a project they would like to carry out:

## ACHIEVEMENTS AND MILESTONES

Achievements (e.g., house built, volunteering, travel, social involvement, etc.):

Significant events in the resident's life, both positive and negative (e.g., trauma, major loss, great pride, immigration, etc.):

## DAILY DIET (AT HOME)

Took 3 meals a day: Yes No

Snacks: Yes No

If yes, what time of day:

Dishes liked:

Less liked dishes or intolerances:

Usual breakfast time:

Usual lunch time:

Usual dinner time:

Mealtime habits:

Enjoyed going to restaurants: Yes No Liked takeout: Yes No

If yes, what:

Their appetite is rather:

Enjoys certain treats (e.g., chocolate, candy, potato chips):

Other:

## ACTIVITIES OF DAILY LIVING

### RESIDENT'S APPEARANCE PREFERENCES

Hair care at the hairdresser's: Yes No

Prefers dyed hair: Yes No

Manicure: Yes No

Pedicure: Yes No

Wears perfume: Yes No

Wears makeup: Yes No

Waxes/shaves: Yes No

Wears a mustache: Yes No

Wears a beard: Yes No

Other preferences:

## USE HABITS (IF APPLICABLE)

Alcohol consumption: Yes No	Frequency:	
Tobacco use: Yes No	Frequency:	
Cannabis use: Yes No	Frequency:	
Other drugs: Yes No	If yes, please specify:	Frequency:

## CLOTHING HABITS

Preferred clothing and special habits (e.g., always wears a camisole):

## WAKE/SLEEP

Sleep quality:	Evening: Good Wakes frequently	Night: Good Wakes frequently	
Usual wake-up time:	Usual bedtime:	Naps: AM PM	
Wishes to be woken up for: Breakfast: Yes No	Lunch: Yes No	Snacks: Yes No	Leisure activities: Yes No
Habits and rituals to promote sleep (e.g., nightlight, reading, music, walking, hot drinks, etc.):			
Others:			

## FAVORITE INTERESTS/ACTIVITIES

### BELIEFS/SPIRITUALITY

What are the person's personal beliefs:

### ENTERTAINMENT

Creative arts	Specify:
Singing	Specify:
Knitting	Specify:
Listening to music	Type/genre:
Watching television	Type/genre:
Others	Specify:
Wears hearing aids: Yes No	Wear glasses: Yes No

Other:

### SOCIAL INTERESTS

Cooking	Playing cards	Having visitors, chatting	Festive events (e.g., parties, exhibition)
Pets	The person has already had pets. If yes, name and breed:		
Hunting	Fishing	Physical activity/sports — Specify:	
Other:			

## INTELLECTUAL INTERESTS

Reading magazines, newspapers, novels	If so, which type:	
Computer/tablet	If yes, please specify the use:	Time allowed:
Board games	If so, which ones:	
Video games	If so, which ones:	Time allowed:
Other:		

## INTERESTS/ACTIVITIES OF DOMESTIC LIFE (AT HOME)

Preparing meals	Cleaning	Managing the budget	Doing laundry, folding
Shopping	Other:		

**A BIT OF MY STORY...** This section will be posted in the room. The important elements of the story will enable the care team to discuss with the resident.

### FOR DISPLAY IN THE ROOM

Can you provide photos (family, friends, etc.) or meaningful objects to personalize the room: Yes No

What are the images that represent the person, that they are passionate about, or that they love and that make them feel good (their job, nature, animals, etc.):

What quotes or sayings do they like or enjoy using:

What's their favorite music:

How would they introduce themselves in just a few sentences:

Signature of the person who completed the form

Name of person who completed the form (capital letters)

Date

## CONFIDENTIALITÉ

I authorize all care providers involved in the care of \_\_\_\_\_ to access the information in this form in order to personalize interventions, taking into account their lifestyle and preferences, and to display the elements of the section in their room: A Bit of My Story.

Signature of the resident or their representative	Name of the resident or their representative (capital letters)	Date
Signature of the provider assisting in completing the form, if applicable	Name of the provider assisting in completing the form, if applicable (capital letters)	Date

References: Histoire de vie, Formulaire d'histoire de vie, Institut universitaire de gériatrie de Montréal and K. Labarre from Voyer (2005) OPUS-AP/PEPS. Institut universitaire de gériatrie de Montréal (2007). Formulaire d'histoire de vie.