

Personal Preference Indicators

Version for Elders and Persons with Disabilities

Developed at the
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through collaboration between:

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Personal Preference Indicators

This document is designed to help you communicate about things in life that you like and things that you dislike. This gives you the opportunity to be involved in making decisions concerning your present and future needs.

Use this document to indicate **your** preferences for everyday activities. Examples are given of what others have said are important to them. **You can choose any of those items, or you can write-in what you want people to know about you.**

The people who provide your care may not know you well. Sometimes you may feel left out of the decision making process. The information that you provide here can help care providers to better understand who you are. Understanding your preferences will help them make your life as enjoyable as possible.

Please be aware that the information you provide on this questionnaire is NOT confidential. The purpose is for nursing, housekeeping, and other care providers to review it and try to accommodate your preferences.

MY PERSONALITY

You can choose any of the listed examples, or you can write in things you would like people to know about you. Use the space provided below each question for details.

Some things about me:

- | | |
|---|---|
| <input type="checkbox"/> I prefer to do activities alone <input type="checkbox"/> I prefer activities with other people <input type="checkbox"/> I like having my personal space <input type="checkbox"/> I like showing affection to others | <input type="checkbox"/> I have a nickname: <input type="checkbox"/> I have a sense of humor <input type="checkbox"/> I consider myself quiet <input type="checkbox"/> I consider myself talkative |
|---|---|

What should your care providers know? How often do you want these preferences met?

What makes me happy?

- | | | |
|--|---|---|
| <input type="checkbox"/> Being outside / inside <input type="checkbox"/> Travel or outings <input type="checkbox"/> Certain music or sounds <input type="checkbox"/> Visiting family or friends | <input type="checkbox"/> Relaxing <input type="checkbox"/> Reading/being read to <input type="checkbox"/> Being around pets <input type="checkbox"/> A special place | <input type="checkbox"/> A TV show <input type="checkbox"/> Certain hobbies / activities <input type="checkbox"/> Certain meals / food <input type="checkbox"/> Other: |
|--|---|---|

What details should your care providers know?

What makes me unhappy?

- | | | |
|--|---|---|
| <input type="checkbox"/> Certain noises <input type="checkbox"/> Certain smells or tastes <input type="checkbox"/> Being rushed <input type="checkbox"/> Being moved/startled <input type="checkbox"/> Certain animals | <input type="checkbox"/> Eating <input type="checkbox"/> Being alone <input type="checkbox"/> Having limited choices <input type="checkbox"/> Slipping / falling <input type="checkbox"/> Lack of privacy | <input type="checkbox"/> Storms / Bad Weather <input type="checkbox"/> Crowds <input type="checkbox"/> Darkness <input type="checkbox"/> Death <input type="checkbox"/> Other dislikes: |
|--|---|---|

What details should your care providers know?

What helps me cope with difficult situations?

- | | | |
|---|--|---|
| <input type="checkbox"/> A safe person <input type="checkbox"/> Music or sounds <input type="checkbox"/> A distraction <input type="checkbox"/> Having people around | <input type="checkbox"/> Pets <input type="checkbox"/> A safe place <input type="checkbox"/> Cigarettes / alcohol <input type="checkbox"/> Other: | <input type="checkbox"/> Spirituality / faith <input type="checkbox"/> Television <input type="checkbox"/> Familiar objects |
|---|--|---|

How would you like your current care providers to help you cope?

MY INDEPENDENCE

My best-functioning times of the day and what I like to do then are:

| TIME OF DAY | ACTIVITY |
|--------------------------------------|-----------------|
| <input type="checkbox"/> Morning | _____ |
| <input type="checkbox"/> Mid-morning | _____ |
| <input type="checkbox"/> Afternoon | _____ |
| <input type="checkbox"/> Evening | _____ |
| <input type="checkbox"/> Late night | _____ |

What details should your care providers know?

I feel strongly about being able to:

| | |
|---|---|
| <input type="checkbox"/> Decorate my own space | <input type="checkbox"/> Go shopping and select items |
| <input type="checkbox"/> Pick out my own clothing | <input type="checkbox"/> Keep automobile/driver's license |

What should your care providers know? How often do you want these preferences met?

I have experienced a recent major change or event that affects:

| | |
|--|--|
| <input type="checkbox"/> My daily routine | <input type="checkbox"/> My role in the family / community |
| <input type="checkbox"/> My leisure activities | <input type="checkbox"/> My health |
| <input type="checkbox"/> My place of residence | <input type="checkbox"/> Other: |

What details should your care providers know about the change or how you cope?

MY FUTURE CONCERNS

| | | |
|---|--|--|
| <input type="checkbox"/> Pain / medication management | <input type="checkbox"/> Being a burden | <input type="checkbox"/> Housing situation |
| <input type="checkbox"/> Independence (mental / physical) | <input type="checkbox"/> Finances | <input type="checkbox"/> Health problems |
| <input type="checkbox"/> Loss of caregivers | <input type="checkbox"/> Mobility | <input type="checkbox"/> Unfinished business |
| <input type="checkbox"/> Loss of privacy | <input type="checkbox"/> Death / End-of-Life | <input type="checkbox"/> Other: |

How would you like your current care providers to help you cope with these concerns?

