

My Life Story

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room:\_\_\_\_\_\_\_\_\_\_

Please try to fill in as much information as possible to help us get to you know you the best that we can.

|  |  |
| --- | --- |
| Place of birth |  |
| The place I grew up  |  |
| The school/college/university I attended |  |
| My biggest achievements in life |  |
| My first job and other jobs that played a significant importance in my life |  |
| Who are the most important people in my life? |  |
| Name of person I was married to/ long term partnership |  |
| My sexuality |  |
| Is touch & intimacy important i.e. cuddles, holding hands etc |  |
| Wedding day memories |  |
| Favourite place I used to live |  |
| Memories of the place I lived the longest and spent my happiest/ saddest time |  |
| Significant events that impacted my life |  |
| What do I like to do? Interests’ hobbies activities (both old and new) |  |
| Events I celebrate due to my faith |  |
| What is important about my appearance? |  |
| Bathing preferences- shower/bath/full body wash |  |
| What support do I require during personal care? |  |
| Swallowing difficulties? |  |
| What I like to eat/drink? |  |
| What drinks/foods do I dislike? |  |
| I like to talk about…. |  |
| Discussion topics that upset me… |  |
| What relaxes me? |  |
| Are there any behaviours that the team at Beulah Vista should be aware of?  |  |
| What could cause me to become distressed? |  |
| My advanced care plan decision? Is my looking ahead form complete? |  |
| The people that know me the most |  |
| End of care decision- who helps with this? |  |
| Are there any medical advanced decisions or directives? |  |
| Do I have a DNAR in place? |  |
| Important things I would like others to understand, how best to care for and communicate with me? |  |
| What I did I enjoy as a child? |  |
| I take my medication in a specific way |  |
| Could I call for help if I needed someone?  |  |
| What helps me to sleep best at night? (light on/off, door open/closed, how many pillows/TV on/off, water by bed, hot drink before bed etc) |  |
| Anything I would like others to know |  |

Filled in by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_