

Town of Hooksett New Hampshire Emergency Management

Functional Needs Assessment

First Name:		Last Name:		Date of Birth:	
Street:			Apt. #	Home Phone:	
E-mail:				Cell Phone:	
What is your living situation?		<input type="checkbox"/> With Spouse	<input type="checkbox"/> Live Alone	<input type="checkbox"/> With Care Giver	TTY #:
Please check all that apply.		<input type="checkbox"/> Other , (specify)			
Functional and Medical Needs					
Primary Language Spoken:				<input type="checkbox"/> Receive Home Health Care Services	
<input type="checkbox"/> Vision Disability	<input type="checkbox"/> Cardiac (heart) Problems		<input type="checkbox"/> Breathing Problems and / or Use a Respirator		
<input type="checkbox"/> Deaf or Hard of Hearing	<input type="checkbox"/> Feeding Tube		<input type="checkbox"/> Diabetes and / or Use insulin		
<input type="checkbox"/> Cognitive Disability	<input type="checkbox"/> On Dialysis		<input type="checkbox"/> Ostomy	<input type="checkbox"/> Intravenous Line	
<input type="checkbox"/> Mental Health Disability	<input type="checkbox"/> Foley Catheter				
<input type="checkbox"/> Allergies (specify)	<input type="checkbox"/> Chemical			<input type="checkbox"/> Environmental	
<input type="checkbox"/> Food		<input type="checkbox"/> Medication			
<input type="checkbox"/> Require the Use of a Service Animal (briefly describe):					
<input type="checkbox"/> Limited Mobility and Use Mobility Equipment (specify):					
Using a Bed or Wheelchair (specify type): <input type="checkbox"/> Standard <input type="checkbox"/> Pediatric <input type="checkbox"/> Oversized <input type="checkbox"/> Reclining <input type="checkbox"/> Motorized					
Can you transfer to a seat for transport?					
<input type="checkbox"/> Use Oxygen, (please specify)					
<input type="checkbox"/> Other Physical and / or Medical Conditions, (please specify)					
Emergency Electrical Power Needs					
<input type="checkbox"/> Medical Equipment <input type="checkbox"/> Heat <input type="checkbox"/> Other, (please specify)					
Transportation Needs					
<input type="checkbox"/> Wheelchair Vehicle <input type="checkbox"/> Ambulance <input type="checkbox"/> Need a Ride <input type="checkbox"/> Other, (specify)					
Communication Needs					
<input type="checkbox"/> Sign / Language Interpreter <input type="checkbox"/> Need Individualized Notification <input type="checkbox"/> Other, (specify)					
Pet Needs					
Pet Name:		Type (dog, cat, etc.)		Breed:	
Weight (approx)		<input type="checkbox"/> Carrier	<input type="checkbox"/> Cage	<input type="checkbox"/> Leash	<input type="checkbox"/> Muzzle
Emergency Contact Information					
Name:		Relationship:		Home:	
Address:		City, State:		Cell:	