Client Intake Form

|  |  |
| --- | --- |
| Date: [MM/DD/YYYY] |  |
| Business Name: |  |
| Address: |  |
| Phone: |  |
| Email: |  |

|  |  |
| --- | --- |
| Name of Referral: |  |
| Relationship to Individual: |  |
| Communication Preference : | Phone Email Video Call |

**CLIENT INFORMATION**:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| First Name: | |  | | | | |
| Last Name: | |  | | | | |
| Gender: | | Female Male | | | | |
| Address: | |  | | | | |
| Phone: | |  | | | | |
| Date of Birth: [MM/DD/YYYY] | |  | | | | |
| Marital Status: | Single Married Divorced Partnered Separated Widowed | | | | | |
| Current Home Setting: | | Residence Hospital Private Residence | | | | |
| Are you currently receiving home care services? | | | | | | Yes No |
| Language Spoken: | | 1st : |  | 2nd: |  | |
| NOTES: | | | | | | |

**MEDICAL**

|  |
| --- |
| How would you rate your current state of health, or the health of the senior you are filling out this form for? |
| **Excellent Good Fair Poor** |

During the last 12 months have you been admitted to the hospital?

|  |  |
| --- | --- |
| Yes No | |
| Date of Admission: MM/DD/YYYY |  | |
| Date of Admission: MM/DD/YYYY |  | |

**INSURANCE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of insurance company: |  | | Policy # |  |
| Do you have medical insurance? | | Yes No | | |
| Are home visits covered? | | Yes No | | |
| Transportation coverage ? | | Yes No | | |

**COVID-19**

|  |  |  |  |
| --- | --- | --- | --- |
| Have you received a vaccination for COVID-19? | | Yes No | |
| Date of vaccination: MM/DD/YYYY | |  | |
| Do you require another injection? | | Yes No | |
| Date of 2nd Dose: |  | Date of 3rd Dose: |  |

**EMERGENCY CONTACT (Primary)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Emergency Contact: | First Name: |  | Last Name: |  |
| Relation to Senior: |  | | | |
| Address: |  | | | |
| Phone No.: |  | | | |
| Email Address: |  | | | |
| NOTES: | | | | |

**EMERGENCY CONTACT (Secondary)**

|  |  |
| --- | --- |
| Emergency Contact: |  |
| Relation to Senior: |  |
| Phone / Email: |  |

**SERVICES REQUIRED (Please select which ones apply)**

**Medical**

|  |  |
| --- | --- |
| **Current medical condition(s):** |  |

Medication Reminders  
Transfer Assistance  
Mobility Assistance

**Personal Care**

Bathing /Toileting/ Grooming  
Dressing Supervision/ Assistance  
Housekeeping  
Meal Preparation and Planning  
Pet Care

**Companionship**

Social engagement  
Coordinate communication with family  
Friendship

**Transportation**

Medical appointments  
Shopping / Errands  
Activities  
 **CARE TYPE**

Acute/Emergency Care  
Respite Care  
Overnight Care  
Live-in  
24/7 Acute Care

**WHEN IS CARE REQUIRED?**

Days  
Evenings  
Night  
Weekends  
Holidays

**CASE MANAGEMENT**

Coordination of services  
Coordinating /attending appointments  
Hospital visits/discharge planning  
Relocation planning and assistance  
Flexibility for emergency assistance  
Provide summary reports of medical appointments

The information provided is true and I agree to be contacted about the required senior care services selected in this form.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | |
| **Client / Authorized person –(Please print)** |  |  | |
| **X** |
| **Client / Authorized person -(Signature)** |
|  |  | |  |
| **Person authorized to review form (Print Name)** |  | | **Title** |
| **X** |  | |  |
| **Person authorized to review form (Signature)** |  | | **Location** |
|  |
| Referral Source:  Friend TV Radio Google Search Social Media Medical Professional | | | | |