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 |