***My Angels Home Care, INC Intake Form***

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| **Individuals’ Information**  | **Today’s Date:**  |
| **Last Name:**  | **Age:****yrs    mths** |
| **First Name:**  | **Date of Birth:** |
| **Middle Name:** | **Gender:** |
|  |  |
| **Home phone:** |  |
| **Address:** |  |
| **City:** |
| **State:****Zip code:** **County:****Country:**  |

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| **Primary Diagnosis:**  | **Date of Diagnosis:**  |
| **Other condition:** | **Date of Diagnosis:** |
| **Other condition:** | **Date of Diagnosis:** |

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| **Family Member Information**  |  |
| **Full Name:** | **Relationship to individual:**  |
| **Address: (if different from applicant)**  |  |
|  |  |
| **City:** | **Occupation:** |
| **State:** | **Name of Employer:** |
| **Home Phone: (if different from applicant)** | **Business Phone:**  |
| **Cell Phone:** |  |
| **Pager:** |  |
| **Fax:** |  |
| **E-mail:** |  |

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| Has the individual ever been admitted to a hospital/treatment center for psychiatric, behavioral, or medical crisis situations? ☐ Yes ☐ No If yes, please explain. |
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| **Are there any medical conditions that need to be considered participating in outdoor activities?**  | **☐** **Yes ☐ No If yes, please explain.** |
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| **What additional support will, if any, the individual will need to live safely in their home and/ or their immediate environment.**  |

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| **Please describe the individuals’ need for Non-Medical Home Care:**  |

Include:

* **Intake Form/ completion**
* **Copy of most medical report/ PPD**
* **Any Additional Health Information**