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

|  |  |  |
| --- | --- | --- |
| **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:** | | |

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

|  |  |
| --- | --- |
| **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:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | |  | |
|  | | | | |
|  | | | | |
|  |  |  | |  |
|  |  |  | |  |
|  |  |  | |  |
|  |  |  | |  |
|  |  |  | |  |
|  |  |  | |  |
|  | | | | |
| Has the individual ever been admitted to a hospital/treatment center for psychiatric, behavioral, or medical crisis situations? ☐ Yes ☐ No If yes, please explain. | | | | |
|  | | | | |

|  |  |
| --- | --- |
| **Are there any medical conditions that need to be considered participating in outdoor activities?** | **☐** **Yes ☐ No If yes, please explain.** |
|  | |

|  |
| --- |
| **What additional support will, if any, the individual will need to live safely in their home and/ or their immediate environment.** |

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

Include:

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