Madea's FAMILY HOME CARE

Compassionate Care. Right At Home.

CLIENT INTAKE FORM

CLIENT INFORMATION

Full Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email (optional): _____

Preferred Language: _____

Marital Status: _____

Veteran: ☐ Yes ☐ No

How did you hear about us? _____

_____

SERVICES REQUESTED

☐ Personal Care ☐ Light Housekeeping

☐ Meal Preparation ☐ Transportation

☐ Medication Reminders ☐ Companionship

Other (please specify): _____

FINANCIAL AGREEMENT

Hourly Rate: $_____

Payment Method: _____

_____

Payment Due:

☐ Weekly ☐ Biweekly ☐ Monthly

Signature: _____

Date: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone (Home): _____

Phone (Cell): _____

Address (if different): _____

_____

City: _____ State: _____ Zip: _____

PHYSICIAN INFORMATION

Primary Physician: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

MEDICAL INFORMATION

Medical Conditions / Diagnoses:

_____

_____

_____

Allergies: _____

Current Medications:

_____

_____

_____

ADDITIONAL INFORMATION

Special Equipment / Assistive Devices Used: _____

_____

Dietary Restrictions: _____

Mobility / Ambulation:

☐ Independent ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

Home Type:

☐ Private Residence ☐ Apartment ☐ Assisted Living ☐ Other: _____

Additional Comments / Notes:

_____

_____

AUTHORIZATION & AGREEMENT

I certify that the information provided is accurate and complete to the best of my knowledge. I authorize Madea's Family Home Care to provide the services requested and to communicate with the above contacts and healthcare providers as needed.

Client / Legal Representative Signature: _____ Date: _____