CLIENT INTAKE FORM

This Client Intake Form collects essential information needed to create a personalized care plan and ensure safe, appropriate, and high-quality home care services. Please complete all sections to the best of your ability. If assistance is needed, a care coordinator will be happy to help.

Section 1: Client Information

Full Legal Name: ____

Preferred Name (if different): _________________________________

Date of Birth: ____________________

Gender: ____________________

Primary Language: ____________________

Secondary Language (if any): ____________________

Home Address: ____

City: ____________________ State: ____________________ ZIP Code: ____________

Primary Phone Number: ____________________

Alternate Phone Number: ____________________

Email Address: ____________________

Living Arrangement:

- ☐ Lives Alone
- ☐ Lives with spouse or partner
- ☐ Lives with family
- ☐ Assisted living or senior housing

Other: ____________________________________

Pets in the Home: ____

Section 2: Primary Contact / Responsible Party

Name: ____

Relationship to Client: ______________________________________

Primary Phone: ___________________

Alternate Phone: ___________________

Email: ___________________

Mailing Address (if different from client):

____

Is this person the legal decision maker for the client

- ☐ Yes
- ☐ No

If no, please list legal representative or guardian (if applicable):

Name: _______________________

Relationship: _______________________

Phone: ______________________

Email: ______________________________

Section 3: Medical Information

Primary Care Physician: _______________________
Phone: ___________________

Specialists (if any): ____

Medical Diagnoses and Conditions:

Allergies (food, medication, environmental):

Hospitalizations in the Last 12 Months:

____

____

Mobility Status:

- ☐ Walks independently
- ☐ Requires assistance
- ☐ Uses cane or walker
- ☐ Wheelchair user
- ☐ Bedbound

Hearing:

- ☐ Normal
- ☐ Hard of hearing
- ☐ Uses a hearing device

Vision:

- ☐ Normal
- ☐ Impaired
- ☐ Blind
- ☐ Uses corrective lenses

Cognitive Status:

- ☐ Alert and oriented
- ☐ Mild impairment
- ☐ Moderate impairment
- ☐ Severe impairment

Notes:

____

____

____

____

____

Section 4: Medication Information

Do you take medications regularly

- ☐ Yes
- ☐ No

If yes, please list medications, doses, and times:

Pharmacy Name: ______________________
Phone: _______________________

Section 5: Daily Routine and Personal Preferences

Preferred Wake Time: __________________

Preferred Bedtime: __________________

Meal Preferences or Dietary Restrictions:

____
____

Religious or Cultural Considerations:

____
____

Activities or Hobbies Enjoyed:

____
____

Household Expectations or Rules:

____
____
____

Section 6: Safety and Support Needs

Assistance Needed With (check all that apply):

- ☐ Bathing and personal hygiene
- ☐ Dressing and grooming
- ☐ Meal preparation
- ☐ Feeding assistance
- ☐ Mobility and transfers
- ☐ Toileting or incontinence care
- ☐ Medication reminders
- ☐ Light housekeeping
- ☐ Transportation or errands
- ☐ Companionship

Other: ____

Safety Concerns in the Home (if any):

____
____
____
____
____

Equipment in the Home:

- ☐ Wheelchair
- ☐ Hospital bed
- ☐ Oxygen
- ☐ Hoyer lift
- ☐ Walker or cane

Other: ____

Section 7: Additional Services or Agencies Involved

Do you currently receive services from another agency or program

- ☐ Yes
- ☐ No

If yes, list provider names and type of support:

____
____

Emergency Response System in Place

- ☐ Yes
- ☐ No

If yes, name of provider: ____

Section 8: Authorization and Signature

I certify that the information provided in this intake form is true and complete to the best of my knowledge. I understand that this information will be used to develop my individualized care plan and coordinate services.

Client Name (printed): ____

Signature of Client or Authorized Representative: ________________________

Date: __________________

Care Coordinator Receiving the Form: __________________________________

Date Received: ____________________