Home Care

Client Intake Form



*Medical Information*

# FIELD DETAILS

PRIMARY PHYSICIAN: PHYSICIAN PHONE NUMBER: EXISTING MEDICAL CONDITIONS: ALLERGIES: MEDICATIONS:

MOBILITY AIDS USED: ☐ WALKER ☐ WHEELCHAIR ☐ CANE ☐ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPECIAL DIET:

DNR ORDER:

POA FOR HEALTHCARE:

* **YES** ☐ **NO**
* **YES** ☐ **NO**

IF YES, NAME OF POA:



*Preferences & Concerns*

PLEASE FILL IN YOUR PREFERENCES AND ANY SPECIFIC CONCERNS:

# PREFERENCES DETAILS

PREFERRED DAYS FOR CARE: PREFERRED TIME FOR CARE: LANGUAGE PREFERENCE: CAREGIVER GENDER PREFERENCE: CULTURAL/RELIGIOUS

* **MON** ☐ **TUE** ☐ **WED** ☐ **THU** ☐ **FRI** ☐ **SAT** ☐ **SUN**
* **MORNING** ☐ **AFTERNOON** ☐ **EVENING**
* **ENGLISH** ☐ **SPANISH** ☐ **OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_**
* **MALE** ☐ **FEMALE** ☐ **NO PREFERENCE**

☐ YES ☐ NO IF YES, PLEASE SPECIFY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRACTICES:

ADDITIONAL

CONCERNS/REQUESTS: