Age Line
General Intake Form

Date of Assessment:_____

Clients Name: _____ DOB:_____

Address:_____ Telephone:_____

_____ Who referred you to Age Line?_____

Directions to the home are attached

Presenting Problem:_____

Should an emergency arise, who would you like us to call? _____

_____

How many children do you have? _____ Names & Telephone:

How often does a family member visit you? Neighbor?

Any neighbor or other person have a key to your home? _____

Phone:_____

If you are incapacitated who makes your financial decisions? _____

Does the same person make your medical decisions? _____

If you were to go to the hospital, which hospital would you prefer? _____

Do you have pets or other household info that would be helpful to the provider?_____

If you are hospitalized who will care for your pet?_____

Do you have a living will?_____ LifeLine?_____ If yes, with which hospital?

Who is your primary physician?_____ Telephone_____

Other physician?_____ Telephone_____

What medications are you currently taking?

Allergies: Food:_____ Drug:_____

Special Diet:_____

Do you cook well-balanced meals for yourself?_____ What did you have for dinner last night?

What are your favorite foods?_____

Have you been hospitalized in the past 6 months? If yes, why?

Client Reported Health

Cardiac Problems:

Pacemaker (Date:_____) Heart Attack CHF CVD Hypertension

Other:_____

Neurological Problems: Have you been diagnosed with any of the following:

Alzheimer's Disease Parkinson's MS Other:_____

Notable Observation:_____

_____

Self Report Dementia:

Do you notice problems with your memory?

If yes, do you eventually remember the previously forgotten event?

Do you experience more problem with your memory now than 6 months ago?
One year ago? Five Years Ago?

Vision:

Do you have Cataracts? Removed:_____

Glaucoma? Wear Glasses? Can you read newsprint?

Respiratory Problems _____ When does this occur?_____

Have you ever had a collapsed lung?_____

Do you have kidney problems?_____Do you use depends products?_____

Do you have bladder problems?

Cancer, including skin cancer:_____

Have you been diagnosed with a blood disorder?_____

Arthritis:_____ If yes, where?_____

Diabetes/Borderline Diabetic:_____ Are you insulin dependent?_____

Anemia:

Limited Mobility:

Do you have any pain? Where?

Fatigue: Back Pain: Rashes/Lesions/Sores/Wounds:

Dizzy Spells: When_____ Can you bend over?

Speech Impairment: Hearing Impairment: Hearing Aid:

Depression: Anxiety:

Acute or Chronic Problems Not Previously Mentioned

Date	Description	Age Line Action Needec

Client Lives In:

Single Home Lives with Others Apartment
Condominium Assisted Living Other:

Living environment is: Clean Neat Cluttered Dirty

Home has: Loose rugs?_____ Observation: Wires exposed/Extension cords.

Portable telephone?_____

Equipment: Wheelchair Oxygen Walker Other:_____

Social History:

Client's Occupation:

Hobbies/Interests:

Religion:

Client is:

Outgoing Pleasant Afraid, if yes why?_____ Tearful, if yes why?_____

Suspicious, if yes of what?_____ Angry, if yes why?_____

Anxious, if yes why?_____ Aggressive Other:_____
Specify other observations

Alcohol/Drugs: Drink? If yes, how many/week?

Do you have a chain or peek hole in your door? Do you use it?

Client is alert: Client is oriented to Time/Person/Place: Client Wanders:

Clothing is: Appropriate Not Clean Unshaven Body odor/urine

Specific Services requested:

Needs Noted During Assessment:
Beginning Services:

Best Days of the Week:_____
Best Time of Day_____

Date	Description of Situation	Action to be Taken