Client Intake Questionnaire

Thank you for your interest in our services! Please read each question carefully and complete the required fields. If any section does not pertain to you, please write **"N/A"**.

Client Information

First name _____ Last Name _____

Phone Number _____ Email Address _____

1. What days and times are most convenient for your services?

   Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐

   Mornings ☐ Afternoons ☐ Evenings ☐

2. Do you live alone or with someone else?

3. Do you have any pets in the home we should be aware of?

4. Are there any cultural or religious preferences we should respect?

Service Goals & Expectations

6. What are your primary goals for receiving in-home support services?

7. Have you received in-home care or support services before?

   Yes ☐ No ☐

8. Are there specific tasks you would like help with regularly?

9. How involved would you or your family like to be in planning your care?

ADLs (Activities of Daily Living) Support

10. Do you need assistance with personal hygiene tasks (e.g., bathing, grooming, dressing)?

    Yes ☐ No ☐

11. Are you able to use the restroom independently?

    Yes ☐ No ☐

12. Do you require support with mobility inside or outside your home?

    Yes ☐ No ☐

13. Do you need help with eating or meal preparation?

    Yes ☐ No ☐

14. Do you need reminders or cues to complete daily personal tasks?

    Yes ☐ No ☐

IADLs (Instrumental Activities of Daily Living) Support

15. Do you need assistance with grocery shopping or running errands?

    Yes ☐ No ☐

16. Would you like help with housekeeping or laundry?

    Yes ☐ No ☐

17. Do you prepare your own meals, or would you like help with meal planning and cooking?

    ☐ I prepare my own meals and would like assistance.

    ☐ I prepare my own meals and would not like assistance.

    ☐ I do not prepare my own meals and would like assistance.

☐ I do not prepare my own means and would not like assistance.

18. Are you able to manage your schedule and appointments, or would you like assistance?

Yes ☐ No ☐

19. Do you need support with organizing mail or household paperwork?

Yes ☐ No ☐

Home Environment & Safety

20. Are there any safety concerns in your home (e.g., fall risks, stairs, clutter)?

21. Is there any assistive equipment in the home (e.g., walker, grab bars)?

22. Do you have a preferred entry method for staff (e.g., key, code, doorbell)?

Boundaries & Comfort

24. Are there specific tasks you prefer staff **not** assist with?

25. Are there any allergies or sensitivities (e.g., scents, cleaning products)?

26. Are there any behavioral triggers or personal boundaries we should be aware of?

27. What makes you feel most comfortable and respected in your home?

Communication & Emergency Protocol

1. Emergency Contact Information

First Name _____ Last name _____

Phone Number _____ Email Address _____

Street Address _____ City _____ State _____ Zip Code _____

Reason For Contact

☐ Medical Emergencies ☐ Cannot Contact you

☐ Changes in Services ☐ Billing Notice / Late Payments

☐ Change in Policy ☐ Plan of Care Follow Up

2. Emergency Contact Information

First Name _____ Last name _____

Phone Number _____ Email Address _____

Street Address _____ City _____ State _____ Zip Code _____

Reason For Contact

☐ Medical Emergencies ☐ Cannot Contact you

☐ Updates in Services ☐ Billing Alert / Delinquent Accounts

☐ Policy Update ☐ Plan of Care Follow Up

28. Is there an advance directive or emergency plan you'd like us to be aware of (without sharing medical details)?

Privacy & Consent

31. Do you consent to us storing your service preferences and care information securely?

    Yes ☐ No ☐

32. Is there anyone else that has not been listed, (family, POA) you authorize us to communicate with about your services? Please list their information below: