KHOBCARE CLIENT INTAKE FORMS- Client Information
Information Provided by: ____ Client _____ Other

Last Name:____ First Name:______________________________ MI:______

Gender: M F DOB:____/_____/_____ SSN:__________________________ DCN:_______________________________

Physical Address:____ City:______________________________

Zip:_______________ Phone Number:________________________________Living Alone: ________ County: ________

Marital Status:

Single Married Divorced Partnered Widowed

Primary Language:________________________________ Care Provider Gender Preference: ______________________

Legal Status:

Power of Attorney/ Responsible Party:_____________________________________ Phone Number:_________________

Veteran: Yes No Branch: Discharge Date Spouse/Widow of Veteran? _____

Ethnicity: ____

Income: Subsidized/Low-Income Housing Medicaid SSI Food Stamps Low Income Other:

Primary Emergency Contact:

Name:____ Phone Number:__________________

Work Phone:____ Relationship:______________________

Email:____

Address:__________________________________ City:_______________________ Zip:__________________

Second Emergency Contact:

Name:____ Phone Number:__________________

Work Phone:____ Relationship:______________________

Email:____

Address:__________________________________ City:_______________________ Zip:___________________

Levels of Assistance:

0 = Independent - Completes the task independently
3 = Minimum Assistance -Occasional assistance or supervision may be necessary
6 = Moderate Assistance - Assistance or supervision is always necessary
9 = Maximum Assistance - Totally dependent on others

Service Information

Nutritional Status

	Yes	Client Rating for this section
I have an illness or condition that made me change the kind/amount of food I eat.	2	
I eat fewer than 2 meals per day.	3	
I eat a few fruits, vegetables, or milk products.	2	
I have 3 or more drinks of beer, liquor, or wine almost everyday.	2	
I have tooth or mouth problems that make it hard for me to eat.	2	
I don't always have enough money to buy the food I need.	4	
I eat alone most of the time.	1	
I take 3 or more different prescribed or over-the-counter drugs a day.	1	
Without wanting to, I have gained or lost 10 pounds in the past 6 months	2	Change:
I am not always physically able to shop, cook or feed myself.	2	Which:
Total score for each Yes response (0-2: low risk; 3-5 moderate risk: 6 or more high risk)		Risk level:

Client :_______________________________________ Signature Date: ______________________________

Office Use Only:

ACTIVITIES OF DAILY LIVING						
Activity	**Ind 0**	**Min. Assist 3**	**Mod. Assist 6**	**Max Assist 9**	**Client Rating in this section**	**Office use only**
Eating						
Bathing						
Grooming						
Dressing						
Toilet Use						
Mobility						
Transferring						

INSTRUMENTAL ACTIVITIES OF DAILY LIVING						
Activity	**Ind 0**	**Min. Assist 3**	**Mod. Assist 6**	**Max Assist 9**	**Client Rating For Care Needs**	**Office Use Only**
Laundry						
Shopping						
Light Housework						
Heavy Housework						
Telephone						
Financial Management						
Transportation						
Meal Preparation						
Medication Management						

				Client response rating for each section
Bathing Equip (bath bench, grab bars, etc)	Have		Don't Have	
Brace (leg, back) prosthesis	Have		Don't Have	
Cane, Crutches, Walker	Have		Don't Have	
Diabetic Supplies	Have		Don't Have	
Dentures	Have		Don't Have	
Railings	Have		Don't Have	
Hospital Bed	Have		Don't Have	

Medical Phone Alert	Have		Don't Have	
Toilet Equipment (ie, raised commode)	Have		Don't Have	
Wheelchair (manual, power)	Have		Don't Have	
Other (specify)				

HOUSEHOLD CONVENIENCES

	Have/Need			**Have/Need**	**Office Use Only**
Electricity			General repair of home exterior		
Gas, Propane			Yard Condition		
Heating System (type?)			Sidewalk, exterior stairs		
Air Conditioner (window or central)			Exterior Lighting		
Fan			Odors (urine, garbage, pets)		
Flush Toilets			General Repair of Home Interior		
Tub, Shower			Interior Clutter		
Piped water, hot/cold			Interior Lighting		
Stove, hotplate, oven, toaster oven			Room Temperature		
Can opener (electric or manual)			Accessibility of Phone(s)		
Microwave			Food Storage		
Blender			Accessibility of fire exits and smoke detectors		
Radio, television			Bugs or rodents inside home		
Refrigerator			Accessibility of emergency phone numbers		
Telephone					
Washer			Unsafe Pathways		
Dryer			Pets		
Comments:			No Problems		

PLACE OF RESIDENCE

What floor does the client live on?_______________ Is the bathroom on the same floor? ______________

Number of steps to enter the home?_____________ Are steps a problem within the home?___________

FALL RISK SCREENING

1. How many times have you fallen in the past year?___________ 2. Are you worried you might have a fall? __________________

3. Do you limit activities now because of fall-related concerns? ____

If the client has NOT fallen in the past year, skip questions 4 & 5 below.

4. Where have you fallen? Getting in & out of bed Bathroom Outside the home Between the bed & the bathroom Kitchen

5. Can you say what makes you more likely to fall?

MEDICAL CONDITIONS

1 - had previously 2 under control 3 - has currently/being treated 4 - has currently

Category	Code	Category	Code	Category	Code	Category	Code
Cardiovascular		**Hearing/Vision**		**Respiratory**		**Skin**	
Ankle edema		Deaf		Asthma		Pressure/other ulcer	
By-pass surgery/ Angioplasty		Hearing deficit		COPD		Rashes	
Chest pain		Hearing aid		Cough (dry/productive)		Shingles	
Circulation problems		Hearing Other		Difficulty breathing		Stasis dermatitis	
Congestive heart failure		Hearing No Problem		Emphysema		Other	
Heart attack		Blind		Oxygen		No problem	
Hypertension		Blurred Vision		Bronchitis		**Genitourinary**	
Hypotension		Cataracts		Pneumonia		Dialysis	
Pacemaker		Glaucoma		Other		Difficulty/frequent urination	
Shortness of breath		Macular Degeneration		No Problem		Dribbling / incontinence	
Other		Vision Other				Frequent bladder infections	
No problem		Vision No Problem				Nighttime urination/ Nocturia	
Endocrine		**Infectious Disease**				Other	
Diabetes		AIDS				No Problem	
Thyroid		HIV positive					
Other		Hepatitis				**Neurological**	

No problem		Tuberculosis				Alzheimer's disease	
		Other				Cerebral Palsy	
Gastrointestinal		No Problem		**Other**		CVA/Stroke	
Abdominal pain				Reduced Physical Stamina		Dementia	
Colitis		**Musculoskeletal**		Dehydration		Dizziness	
Constipation		Amputation of:		Allergies - food/ medicine		Paralysis of:	
Diarrhea		Arthritis - rheumatoid or osteo		Anemia		Parkinson's Disease	
Difficulty swallowing		Back pain		Autism		Seizures/epilepsy	
Diverticular disease		Contractures		Cancer		Multiple Sclerosis (MS)	
Frequent use of laxatives		Fracture of:		Developmental disability		Amyotrophic lateral sclerosis	
Gallbladder problems		Joint replacement of:		Depression		Other	
Indigestion		Polio/Post Polio		Drug use/abuse		No Problem	
Irritable bowel syndrome		Other		Mental retardation		**PAIN**	
Ulcers		No problem		Tobacco use		Are you in pain now? If yes, rate your level of pain on a scale of 1 - 10 (1 indicates no pain, 10 indicates the most intense level of pain) PA**IN LEVEL:** ___________	
Other				Obesity			
No problem				Chronic pain			
				Other			
				No problem			

MEDICAL PERSONNEL

Primary Doctor: ____ Phone Number (___) ___ - ________

Client Name:____Date:__________________________

Representative Name:____ Date:_________________________

Important Information for Client's

Services will be terminated if KHOBCARE, LLC is notified of additional fee's for services is rendered to our staff during/after their scheduled shift hours. Client's are not permitted to offer gifts in the form of cash for services rendered. KHOBCARE, LLC has the right to revoke services immediately as this violates our policies and violates regulations with the Department of Social Services. Please contact the office with any questions or concerns.

Clients, Will like to start services effective on: ____________________________ Start Time:________________

Representative Signature: ____ Date: _________________