2025

Adult Caregiver Needs

Person Submitting Form:

Relationship:

Legal authority to care for client

Contact Information:

Phone:

Address

Address

City

State

Zip

Client Information

- Full Name:
- Date of Birth:
- Gender:
- Primary Language(s) Spoken:
- Contact Information (Phone & Email):
- Home Address:
- Emergency Contact Name & Relationship:
- Emergency Contact Phone:
- Power of Attorney (if applicable): ☐ Yes ☐ No
- Primary Care Physician:
- Physician’s Contact Info:

Medical History & Health Conditions

• Primary Diagnosis:

• Secondary Diagnoses:

• Cognitive Impairments (e.g., Dementia, Alzheimer's, TBI):

• Mental Health Conditions (e.g., Depression, Anxiety, PTSD):

• Chronic Pain or Physical Disabilities:

• Hearing and/or Vision Impairments:

• Allergies (Food, Medication, Environmental):

• Recent Surgeries or Hospitalizations (Last 12 Months):

• Medical Equipment Used (CPAP, Oxygen, Nebulizer, etc.):

• Do they require a feeding tube or specialized diet? ☐ Yes ☐ No

• Specialized Medical Needs (e.g., Wound Care, Catheter, Colostomy):

• Medications Taken & Dosage: (Attach list if needed)

MEDICATION	DOSAGE	TIME(S) TAKEN

Care Needs Assessment

1. Safety & Navigation Assistance

• Does the client experience confusion, wandering, or disorientation? ☐ Yes ☐ No

• Are there known safety concerns (e.g., leaving the stove on, opening doors unsupervised)? ☐ Yes ☐ No

• Does the client need supervision to prevent falls or accidents? ☐ Yes ☐ No

• Are there mobility aids in use (e.g., walker, cane, wheelchair)? ☐ Yes ☐ No

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2. Memory Support & Routine Management

• Has the client been diagnosed with dementia or cognitive impairment? ☐ Yes ☐ No

• Do they need reminders for daily tasks (e.g., bathing, eating, medications)? ☐ Yes ☐ No

• Are there concerns with agitation, sundowning, or confusion? ☐ Yes ☐ No

• Preferred daily routines or activities that help them feel comfortable:

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3. Physical Function & Pain Management Support

• Does the client have chronic pain? ☐ Yes ☐ No

• Are they currently undergoing physical therapy? ☐ Yes ☐ No

• Are there certain movements or tasks that cause pain or discomfort? ☐ Yes ☐ No

• Do they need assistance with transfers (e.g., bed to chair, chair to toilet)? ☐ Yes ☐ No

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4. Personal Hygiene & Dressing Assistance

• Can the client bathe independently? ☐ Yes ☐ No

• Do they require assistance with oral care, shaving, hair care? ☐ Yes ☐ No

• Can they dress independently? ☐ Yes ☐ No

• Do they use incontinence products? ☐ Yes ☐ No

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5. Mobility & Fall Prevention

• Has the client had a fall in the last six months? ☐ Yes ☐ No

• Do they need support while walking or standing? ☐ Yes ☐ No

• Is their home equipped with grab bars or fall prevention equipment? ☐ Yes ☐ No

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6. Meal Preparation & Feeding

• Does the client have difficulty chewing or swallowing? ☐ Yes ☐ No

• Do they have specific dietary restrictions or preferences?

• Can they feed themselves independently? ☐ Yes ☐ No

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7. Social & Emotional Engagement

• Preferred social activities (e.g., church, hobbies, music, puzzles):

• Do they enjoy being around family and friends? ☐ Yes ☐ No

• Are there signs of depression, loneliness, or withdrawal? ☐ Yes ☐ No

• Would they benefit from companionship care? ☐ Yes ☐ No

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8. Transportation & Errands

• Does the client need transportation for medical appointments? ☐ Yes ☐ No

• Do they require assistance for grocery shopping or running errands? ☐ Yes ☐ No

• Can they safely navigate public transportation or rideshares? ☐ Yes ☐ No

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9. Medication Support

• Does the client manage their own medications? ☐ Yes ☐ No

• Do they require reminders or supervision for medication administration? ☐ Yes ☐ No

• Are medications in a pill organizer or dispenser? ☐ Yes ☐ No

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10. Housekeeping Services

• What household tasks does the client need help with? (Check all that apply)

☐ Laundry

☐ Dishes

☐ Vacuuming/Sweeping

☐ Bed Making

☐ Trash Removal

☐ General Organization

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11. Financial & Household Organization

• Does the client need help with managing mail, bills, or paperwork? ☐ Yes ☐ No

• Are there any financial or legal concerns requiring assistance? ☐ Yes ☐ No

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12. Emergency Monitoring & Response

• Does the client have a medical alert system? ☐ Yes ☐ No

• Do they have a Do-Not-Resuscitate (DNR) order? ☐ Yes ☐ No

• Are emergency contacts aware of their medical history? ☐ Yes ☐ No

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Additional Notes & Preferences

• Preferred schedule for caregiver services (days & times):

• Are there specific cultural or religious preferences for caregiving?

• Are there pets in the home? ☐ Yes ☐ No (If yes, list type and any care needs)

• Any additional requests or concerns:

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Caregiver Preferences

• Preferred gender of caregiver: ☐ Male ☐ Female ☐ No preference

• Language preference:

• Are there specific skills or training required? (e.g., dementia care, CPR, mobility support)

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Authorization & Agreement

I confirm that the information provided is accurate and complete. I consent to share this information with the caregiver or agency for proper care planning.

Client/Representative Name:

Signature:

Date: