Client Intake Form

Client Basic Information

Full Name: _____ Phone: _____

Email Address: _____

Address: _____

Name of Emergency Contact: _____

Phone: _____ Email: _____

Medical Information

Primary Care Provider: _____

Clinic/Hospital Name: _____ Contact Number: _____

Known Allergies: _____

Medical Conditions	Current Medications (Including Dose and Frequency)

Client Status

Health Status	Level/Ability (Tick appropriate cell)				
	Excellent	Good	Decent	Poor	Very Poor
Health Status					
Communication					
Sight					
Hearing					
Speech					
Mobility					

Level of Care Required: ◯ Supervision ◯ Partial Assistance ◯ Complete Assistance

Primary Language: _____ Other Languages: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed

Smokes? ◯ Yes ◯ No Lives Alone? ◯ Yes ◯ No Has Pets? ◯ Yes ◯ No

Required Services

Required Services:

◯ Bathing ◯ Grooming ◯ Dressing ◯ Mobility Assistance ◯ Transportation

◯ Companionship ◯ Medication Management ◯ Meal Planning & Prepping

◯ Light Housekeeping ◯ Health Monitoring ◯ Running errands ◯ Pet Care

◯ Grocery Shopping ◯ Toileting ◯ Social Activities ◯ Exercise & Physical Activity

Other Services: _____

Additional Notes on Required Services and Reasons for Care Inquiry:

Preferred Schedule

Required Days	Required Time (Tick as Required)				
	Morning	Afternoon	Evening	Full Day	Overnight
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					

Preferred Start Date: _____ Services Required For (e.g., 1 year): _____

Contact Preferences

Preferred Method of Contact: ◯ Phone ◯ Email ◯ Text ◯ Video Call

Preferred Contact Timing: ◯ Morning ◯ Afternoon ◯ Evening ◯ Flexible

Preferred Person of Contact (For Updates on Schedule and Other Matters):

◯ Client ◯ Others

If others, specify name and relationship with client: _____

Insurance Information

Insurance Provider: _____ Policy Number: _____

I consent to the collection and use of the information provided in this intake form for the purpose of determining my care needs and coordinating services. I understand that I am responsible for providing accurate and complete information to the best of my knowledge to ensure the appropriate care is delivered.

Client Signature: _____ Date: _____