Intake Form

CLIENT

First Name	Last Name	Goes By
Gender	Birth Date	Today's Date

RESIDENTIAL ADDRESS

Line 1		Line 2
City	State	Zip Code

CLIENT PHONE

Home Phone	Mobile Phone

RESP PARTY #1

Name	Relationship
Resp. Party #1: Email	
Number	Number 2

HEALTH INFORMATION

Primary Physician	Physician Phone
Diagnosis (1st) (Description)	Diagnosis (2nd) (Description)
Diagnosis (3rd) (Description)	Diagnosis (4th) (Description)
Hospitalizations: Date/Reason	Functional Aide(s)

INSURANCE INFORMATION

Medicare Number	Social Security Number / ssn	
LTC Insurance Provider	Phone Number	Policy Number
Other Insurance Provider	Phone Number	Policy Number

PREFERENCES

Service	Visit Type	Caregiver Gender	Caregiver Speech	Caregiver Language
◯ Personal Care ◯ Companion ◯ Transportation Only	◯ Hourly ◯ 24 Hr: Split-Shift ◯ 24 Hr: Live-in	◯ Male ◯ Female ◯ Any	◯ No Accent ◯ Slight Accent Ok ◯ N/A	◯ English ◯ Spanish ◯ Other
Heavy Lifting Needed	**Driving Needed**	**Car Needed**	**Smoking Household**	**Pets**
◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Pet1	Pet2	Pet3
Caregiver Schedule	Additional Preferences	
Previous Bad Experiences with Agencies/Caregivers		

ADLs

- ☐ Homemaking
- ☐ Bed Bath
- ☐ Feed Client
- ☐ Prepare Meals
- ☐ Serve Meals
- ☐ Shower
- ☐ Tub Bath
- ☐ Assist with Bedpan
- ☐ Assist with Commode
- ☐ Assist with Dressing
- ☐ Assist with Toileting
- ☐ Comb Hair
- ☐ Nails
- ☐ Oral Hygiene
- ☐ Peri Care
- ☐ Shampoo
- ☐ Shave
- ☐ Skin Care
- ☐ Assist with Ambulation
- ☐ Assist with Cane
- ☐ Assist with Crutches
- ☐ Assist with Transfers
- ☐ Assist with Walker
- ☐ Empty Drainage Bag
- ☐ OOB in Wheelchair
- ☐ OOB w/ Assist
- ☐ Range of Motion
- ☐ Remind to Take Medication
- ☐ Return to Bed with Assist
- ☐ Turn and Position

ADDITIONAL INFORMATION

Receiving Therapy?	Name of Other Company	
Other Residents	Do they have a caregiver? If yes, which company?	
Languages Spoken	Occupation	
Referral	Rate	Approximate Start Date
Comments		