PATIENT INTAKE FORM

Patient Name: _____ DOB:_____ Sex: ____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Home #: _____ Patient Cell #: _____

List any other residents: _____ Do they have an aide? _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Cell: _____ □□ Texting Emergency Contact Home:

_____

***How did you hear about us?* _____ Emergency Contact E-mail: _____**

Rehab: □□ M&M □□ None □□ Other: _____ □□ In-home □□ Outpatient

□□ Skilled Nursing

Physician: _____ Telephone: _____

Diagnosis: _____ Hospitalizations: _____

Functional Aid: □□ Wheelchair □□ Walker □□ Cane

LTC Insurance Provider: _____ LTC Phone #: _____ Policy #: _____

SSN: _____ Medicare #: _____

Medical Insurance / VA Benefits: _____ Policy #: _____

Languages: _____ Patient/Spouse Previous/Current Occupation: _____

Caregiver Schedule: _____ Caregiver Preferences: _____

Explain any previous bad experiences / unfit caregivers: _____

Pets? □□Yes □□No Smoking? □□Yes □□No Heavy Lifting? □□Yes □□No Driving

Needed? □□Yes □□ No

Approximate Service Start Date: _____

Rate □ Hourly □ Live-In: _____

Caregiver Duties & Care Comments: _____

_____

_____