INTAKE Questionnaire

Care and Keeping
LET'S GO HOME

CLIENT INFORMATION

Name: _____ Date: _____
Secondary Name: _____
Mobile: _____ Email: _____
Home Phone: _____ Other: _____,_____
Address: _____

Are you married? ☐ Yes ☐ No Pets? ☐ Yes ☐ No
Have children? ☐ Yes ☐ No Veteran? ☐ Yes ☐ No
Family members & Relationship_____
_____

FINANCIAL & LEGAL INFORMATION

Do you have a POA? ☐ Yes ☐ No
Financial POA Name: _____ Mobile: _____
Email: _____
Medical POA Name: _____ Mobile: _____
Email: _____
Care Manager: _____ Mobile: _____
Email: _____
Other: _____
Reason for seeking supportive services?
_____
_____
Budget: _____
Do you have a long-term care policy? ☐ Yes ☐ No
If so who is it through? _____
Do you have any potential income? ☐ Yes ☐ No
If so, what type and when? _____
_____
_____

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FINANCIAL & LEGAL INFORMATION

Do you have an estate plan? ☐ Yes ☐ No
If not, would you like more information? ☐ Yes ☐ No
Are you planning to use Medicaid funding (now and in the future)? ☐ Yes ☐ No
Notes:

HOUSING & LOCATION

Current Living Situation: _____

Community Type: ☐ Adult Foster Care ☐ Independent ☐ Assisted ☐ Memory Care

What is your ideal move-in date?: _____
Location preference? _____

Any special requirements? _____

Religious preference?_____

Notes: _____

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HEALTH

Primary Care Dr: _____ Phone: _____
Specialists: _____
Immediate Health Concerns: _____
_____
Sleeping Habits: _____
_____
Food Preferences: _____
_____
Food Allergies? ☐ Yes ☐ No
If so, what type? _____
Do you need any help with ADL's ☐ Meds ☐ Showering ☐ Dressing ☐ Eating ☐ Bathroom
Continent? ☐ Yes ☐ No Other _____
Diabetes? ☐ Yes ☐ No If yes: ☐ Insulin Dependent ☐ Sliding Scale
Activity Preferences: _____
_____
Daily Routine? _____
_____
Health Issues: ☐ Parkinson's ☐ Dementia ☐ Alzheimer's ☐ MS ☐ Mental Health
Other: _____
DME Required? ☐ Oxygen ☐ Catheter ☐ Colostomy ☐ Walker ☐ Feeding Tube
☐ Wheelchair ☐ Two Person Transfer ☐ Hoyer ☐ Sit to Stand ☐ Wound Care
Height: _____ Weight: _____
Notes: _____
_____
_____
_____
_____
_____