

CLIENT INTAKE

Client Name	
Client Address	
Client Phone	()

Caller Name	
Caller Address	
Caller Phone	()
Relationship to Client	
How did you hear about Generations?	

What is the CURRENT SITUATION, the reason for seeking in-home assistance for Client?	
How would you characterize Client's PRESENT BEHAVIOR?	<input type="checkbox"/> Anxious <input type="checkbox"/> Assaultive <input type="checkbox"/> Cooperative <input type="checkbox"/> Depressed <input type="checkbox"/> Disruptive <input type="checkbox"/> Isolated <input type="checkbox"/> Other _____ _____

How would you characterize Client's current MENTAL STATE?	<input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Forgetful <input type="checkbox"/> Oriented (reasonably aware as to time, place and person) <input type="checkbox"/> Unresponsive <input type="checkbox"/> Other _____ _____
Does Client have any MAJOR PHYSICAL LIMITATIONS?	<input type="checkbox"/> Hard of hearing <input type="checkbox"/> Blind <input type="checkbox"/> Not ambulatory <input type="checkbox"/> Other _____ _____
Are there specific matters Client NEEDS ASSISTANCE WITH?	<input type="checkbox"/> Ambulation/transfers <input type="checkbox"/> Feeding <input type="checkbox"/> Meal preparation <input type="checkbox"/> Dressing/grooming <input type="checkbox"/> Elimination/ toileting <input type="checkbox"/> Household management <input type="checkbox"/> Medication reminders <input type="checkbox"/> Other _____ _____ <input type="checkbox"/> Comments _____ _____

Does Client have any ALLERGIES? Please specify			
Are there PETS in the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are there SMOKERS in the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No

