MILLIES HOME CARE AGENCY

IN-TAKE FORM

Form Completed by:	**Date:**

Client's Name_____Date of Birth:_____

Adress_____Phone:_____

Social Security #_____ Referred by:_____

Reason_____

Emergency Contact #1 Name/Relationship_____

Telephone: Home_____ Cell_____Work_____

Emergency Contact #2 Name/Relationship_____

Telephone: Home_____Cell_____Work_____

Emergency Contact #3 Name/Relationship_____

Telephone: Home_____Cell_____Work_____

Financial Arrangements:

Booking Fee Received_$_____ Payment Schedule: Quarterly, Bi-annual

Type of Payment: Cash, Debit, Credit, Check

PROPOSED SCHEDULE

Start Date_____ End Date:_____ Total Number of Hours/day/Week_____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday

COMMENTS/NEEDS

_____
_____
_____
_____

INTAKE HEALTH SUMMARY

Physicians Name_____Phone Number_____ Cell_____

Social Worker's Name_____ Phone Number_____ Cell_____

Health Conditions:_____

Medication/Allergies_____

Surgeries/Hospitalization in the last 3 years_____

Infections:

Diarrhea	UTI	Respiratory	Eye/Ear

Communicable Disease:

HIV/AIDS	MEASLES	TB	STD

Wounds: Yes or No

Is the drainage from the wound contained?_____

Location_____

What kind of dressing is being used?_____

Behavioral Needs:

Aggression or combativeness? Yes or No

Verbal Inappropriateness? Yes or No

Wanders ? Yes or No

Habits and Tendencies: (please circle the following)

Toileting Independence Yes or No	Wears Depends	Catheter/Ostomy	Oxygen Yes or No Liter/Min____	Smoker How often____	Dizziness/Loss of balance
Fall Risk	Hearing Problems	Vision Problems	Dentures	Mobility devices used Yes or No	Wheel Chair Cane Walker
Ambulation Assist	Dietary: Needs Assistance ? Yes or No	Ground- Cut-up- Thickened Liquids	Visual: Wears Prescription Glasses Reading glasses Contacts	Sleep Walking	Others: