Compassion Care In-Home Health

New Client Intake Form

Today's Date:

Name of Person Completing Form:

Client First and Last Name:

Address, City, Zip:

Date of Birth:

Age in Years:

Home Phone Number:

Cell Phone Number:

Your Email: (You will be emailed a copy of this form with the email provided here)

Gender: ☐ Male ☐ Female ☐ Other

Birth Place: (City, State, Country)

Primary Care Physician Name:

Physician office address: (city, state)

Physician Office Phone Number:

Physician Office Fax Number:

Primary Diagnosis:

Approximate Month / Year:

Secondary Diagnosis:

Approximate Month / Year:

Any other Diagnosis: ☐ Yes ☐ No

Client Detail:

☐ Check Here for enter Client Details

Previous Occupation:

College or University:

Location of Upbringing:

Languages Spoken:

Childhood Health: (Good or Bad please Describe)

Previous Cities or Towns of Residence:

Pets Names & Type of Animal:

Interests / Hobbies:

Social/ Family issues or Concerns:

Caregiver Name:

Caregiver Phone Number:

Caregiver 2nd Phone Number if:

Caregiver Email:

Names and Ages of ALL people living in House with Client:

Close Friend Name:

Close Friend Phone Number:

Check here for enter more details: ☐ If have another Close Friend

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Living Relatives:

Mother: ☐ **Yes** ☐ **No**

Father: ☐ **Yes** ☐ **No**

Brothers: ☐ **Yes** ☐ **No**

Sisters: ☐ **Yes** ☐ **No**

Children:

Daughters: ☐ **Yes** ☐ **No**

Sons: ☐ **Yes** ☐ **No**

Religious Affiliation:

Name of Church:

Church address: (City, State and Zip)

Clergy / Rabbi Name:

Clergy / Rabbi Phone Number:

Physician: ☐ Yes ☐ No

2nd Physician: ☐ Yes ☐ No

Pharmacy: ☐ Yes ☐ No

Dentist: ☐ Yes ☐ No

Optometrist: ☐ Yes ☐ No

Optician Store: ☐ Yes ☐ No

Podiatrist: ☐ Yes ☐ No

Chiropractor: ☐ Yes ☐ No

Current Specialists (if any): ☐ Yes ☐ No

Other: ☐ Yes ☐ No

Any Service(s): ☐ Yes ☐ No

Is Client Able to Speak & Hear Correctly on Telephone: ☐ Yes ☐ No

Does Client/ Caregiver have Access to Reliable Internet: ☐ Yes ☐ No

Does Client/Caregiver have Cell Phone: ☐ Yes ☐ No

List Clients Favorites:

Hobbies:

Pets:

Food:

Color:

TV Shows:

Favorite Anything Other:

List What Makes Client Happy:

List Any Stresses:

List What Makes Client Sad:

List All Medical Conditions & Controlled, Remission, etc.: (ex: High Blood Pressure, controlled with meds)

Surgeries & Dates: ☐Yes ☐No

List All Illnesses, Including Childhood Illnesses:

List Any & All Infectious Diseases:

List All Hospitalizations & Dates:

List Any Significant Physical Trauma like Car Accidents, Falls:

List All Current Treatments & If Working & Any Improvements:

List All Current Therapy's & If Working & Any Improvements:

List All Medications & Dosage, Routes, Times:

List of All Specialized Medical Equipment:

List of All Adaptive Tools:

List of All Allergies & Allergic Responses:

Any Additional Comments/Remarks that You Want Us to Know or Be Aware of:

Client Signature:

Caregiver's Printed Name:

Caregiver's Signature:

Electronic Signature Disclaimer

Please ensure all information is correct before hitting Submit, as this is a Legal Document, and may be used in legal proceedings. Your signature is made with intent, and by signing your name electronically to this **Intake Basic Information & Medical History**, you are agreeing that your signature is the legal equivalent of your manual signature. If you want to opt out of the online **Intake Basic Information & Medical History**, or any other online form, please contact the office and paper forms will be sent to you.