CLIENT INTAKE FORM - IN-HOME SERVICES

Client Information **Information Provided by: ____ Client _____ Other**

Last Name:_____ First Name:_____ MI:_____

Gender: M F DOB:_____/_____/_____ SSN:_____ DCN:_____

Address:_____ City:_____ Zip:_____

Phone Number:_____ Living Alone: ___ Y ___ N

County: ___ Cass ___ Clay ___ Jackson ___ Platte ___ Ray ___ Other:

Marital Status: ___ Single ___ Married ___ Divorced ___ Partnered ___ Separated ___ Widowed (date of spouse's death):

Primary Language: ____ English ___ Spanish ___ Other:

Legal Status: ___ Responsible for Self ___ Power of Attorney ___ Guardian

Name:_____ Phone Number:_____

Eligibility: ___ Age

Veteran: ___ Yes ___ No Branch: Discharge Date:

Spouse/Widow of Veteran? ___ Yes ___ No

Ethinicity: ___ Hispanic/Latino ___ Not Hispanic/Latino

Citizenship Status

Race (mark more than one if necessary): ___ African-American ___ Am. Indian/Native Alaskan ___ Asian ___ Native Hawaiian/Pacific Islander ___ White ___ Other:

___ US Citizen
___ Permanent Res.

Income: ___ Subsidized/Low-Income Housing ___ Medicaid ___ SSI ___ Food Stamps ___ Low Income ___ Other:

Primary Emergency Contact:

Name:_____ Aware they are emergency contact? Y N

Home Number:_____ Work Phone:_____ Relationship:_____

Cell Number:_____ Email:_____

Address:_____ City:_____ Zip:_____

Second Emergency Contact:

Name:_____ Aware they are emergency contact? Y N

Home Number:_____ Work Phone:_____ Relationship:_____

Cell Number:_____ Email:_____

Address:_____ City:_____ Zip:_____

Service Information

MARC Service Area:_____ Service(s):_____

Service Provider:_____

Client Name: _____ Page 2

Referral Information

____ Abuse/Neglect	____ Adult Day Care	____ Advocacy	____ Animal Services	____ Case Mgmt
____ Caregiver Services	____ Property Tax Credit	____ Dental	____ Disabilities	____ Food
____ Funeral	____ Health Centers	____ Hearing	____ Home Health	____ Homemaker
____ Home Repairs	____ Home Del. Meals	____ Housing Options	____ Legal Services	____ Mental Hlth Srvs.
____ Ombudsman	____ Personal Care	____ Senior Center	____ Transportation	____ Veterans
____ Vision	____Other:			

Nutritional Status

	Yes	Comment
I have an illness or condition that made me change the kind/amount of food I eat.	2	
I eat fewer than 2 meals per day.	3	
I eat few fruits, vegetables, or milk products.	2	
I have 3 or more drinks of beer, liquor, or wine almost everyday.	2	
I have tooth or mouth problems that make it hard for me to eat.	2	
I don't always have enough money to buy the food I need.	4	
I eat alone most of the time.	1	
I take 3 or more different prescribed or over-the-counter drugs a day.	1	
Without wanting to, I have gained or lost 10 pounds in the past 6 months	2	Change:
I am not always physically able to shop, cook or feed myself.	2	Which:
Total score for each Yes response (0-2: low risk; 3-5 moderate risk: 6 or more high risk)		Risk level:

Client
Signature Date

Intake Worker
Signature Date

Referral Source: Telephone Number:

Notes:

FUNCTIONAL ASSESSMENT

Levels of Assistance:

0 = Independent - Completes the task independently

3 = Minimum Assistance -Occasional assistance or supervision may be necessary

6 = Moderate Assistance - Assistance or supervision is always necessary

9 = Maximum Assistance - Totally dependent on others

1. For each activity check the box indicating the assistance needed.
2. If assistance is needed, indicate the source of help (**be specific: spouse, family, friend, paid help, volunteer, professional)**
3. In the comments section indicate the type of assistance provided and how often it is provided. Also indicate if the client needs further help.

ACTIVITIES OF DAILY LIVING

Activity	**Ind 0**	**Min. Assist 3**	**Mod. Assist 6**	**Max Assist 9**	**Primary Source of Help**	**Comments / Other Sources**
Eating						
Bathing						
Grooming						
Dressing						
Toilet Use						
Mobility						
Transferring						

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Activity	**Ind 0**	**Min. Assist 3**	**Mod. Assist 6**	**Max Assist 9**	**Primary Source of Help**	**Comments / Other Sources**
Laundry						
Shopping						
Light Housework						
Heavy Housework						
Telephone						
Financial Management						
Transportation						
Meal Preparation						
Medication Management						

Adaptive Equipment	**Has**	**Has, Does Not Use**	**Needs**	**Comments**
Bathing Equip (bath bench, grab bars, etc)				
Brace (leg, back) prosthesis				
Cane, Crutches, Walker				
Diabetic Supplies				
Dentures				
Railings				
Hospital Bed				
Medical Phone Alert				
Toilet Equipment (ie, raised commode)				
Wheelchair (manual, power)				
Other (specify)				

Client Name:_____

HOUSEHOLD CONVENIENCES

	Client Has	Client Needs	Observation: Does the client's home have health and safety issues related to any of the following?		
Electricity			General repair of home exterior		
Gas, Propane			Yard Condition		
Heating System (type?)			Sidewalk, exterior stairs		
Air Conditioner (window or central)			Exterior Lighting		
Fan			Odors (urine, garbage, pets)		
Flush Toilets			General Repair of Home Interior		
Tub, Shower			Interior Clutter		
Piped water, hot/cold			Interior Lighting		
Stove, hotplate, oven, toaster oven			Room Temperature		
Can opener (electric or manual)			Accessibility of Phone(s)		
Microwave			Food Storage		
Blender			Accessibility of fire exits and smoke detectors		
Radio, television			Bugs or rodents inside home		
Refrigerator			Accessibility of emergency phone numbers		
Telephone					
Washer			Unsafe Pathways		
Dryer			Pets		
Comments:			No Problems		

PLACE OF RESIDENCE

What floor does the client live on?_____ Is the bathroom on the same floor? Yes No

If the client lives on other than the main floor: Is there an elevator, lift or stair lift? Yes No

Number of steps to enter the home?_____ Are steps a problem within the home? Yes No

Ask the Client the following: Do you have difficulty getting into your home? Yes No
Do you have difficulty getting into any room in your home? Yes No

Comments:

FALL RISK SCREENING (ask the client the following questions)

1. How many times have you fallen in the past year?_____
2. Are you worried you might have a fall? Not at all A little Somewhat Very
3. Do you limit activities now because of fall-related concerns? Never Occasionally Sometimes Often

If client has NOT fallen in the past year, skip questions 4 & 5 below.

4. Where have you fallen?
   - Getting in & out of bed
   - Between the bed & the bathroom
   - Bathroom
   - Kitchen
   - Outside the home
   - Other:

5. Can you say what makes you more likely to fall?
   - Feeling dizzy/lightheaded
   - Certain Shoes
   - Stairs
   - Getting up too quickly
   - Turns
   - Dim Lighting
   - Walking in darkness
   - Walking on certain surfaces
   - Other:

Client Name:_____

MEDICAL CONDITIONS

What are your medical problems? (use the following codes to answer)
1 - had previously 2 - under control
3 - has currently/being treated 4 - has currently/ not being treated

Height: _____

Weight: _____

Category	Code	Category	Code	Category	Code	Category	Code
Cardiovascular		**Hearing/Vision**		**Respiratory**		**Skin**	
Ankle edema		Deaf		Asthma		Pressure/other ulcer	
By-pass surgery/ Angioplasty		Hearing deficit		COPD		Rashes	
Chest pain		Hearing aid		Cough (dry/productive)		Shingles	
Circulation problems		Hearing Other		Difficulty breathing		Stasis dermatitis	
Congestive heart failure		Hearing No Problem		Emphysema		Other	
Heart attack		Blind		Oxygen		No problem	
Hypertension		Blurred Vision		Bronchitis		**Genitourinary**	
Hypotension		Cataracts		Pneumonia		Dialysis	
Pacemaker		Glaucoma		Other		Difficulty/frequent urination	
Shortness of breath		Macular Degeneration		No Problem		Dribbling / incontinence	
Other		Vision Other				Frequent bladder infections	
No problem		Vision No Problem				Nighttime urination/ Nocturia	
Endocrine		**Infectious Disease**				Other	
Diabetes		AIDS				No Problem	
Thyroid		HIV positive					
Other		Hepatitis				**Neurological**	
No problem		Tuberculosis				Alzheimer's disease	
		Other				Cerebral Palsy	
Gastrointestinal		No Problem		**Other**		CVA/Stroke	
Abdominal pain				Reduced Physical Stamina		Dementia	
Colitis		**Musculoskeletal**		Dehydration		Dizziness	
Constipation		Amputation of:		Allergies - food/ medicine		Paralysis of:	
Diarrhea		Arthritis - rheumatoid or osteo		Anemia		Parkinson's Disease	
Difficulty swallowing		Back pain		Autism		Seizures/epilepsy	
Diverticular disease		Contractures		Cancer		Multiple Sclerosis (MS)	
Frequent use of laxatives		Fracture of:		Developmental disability		Amyotrophic lateral sclerosis	
Gall bladder problems		Joint replacement of:		Depression		Other	
Indigestion		Polio/Post Polio		Drug use/abuse		No Problem	
Irritable bowel syndrome		Other		Mental retardation		**PAIN**	
Ulcers		No problem		Tobacco use		Are you in pain now?	
Other				Obesity		If yes, rate your level of pain on a scale of 1 - 10 (1 indicates no pain, 10 indicates the most intense level of pain)	
No problem				Chronic pain			
				Other			
				No problem		PA**IN LEVEL:** _____	

Client Name:_____ Page 6

MEDICAL PERSONNEL

Primary Doctor: _____ Phone Number (____) ____ - _____

Other In-home provider name: _____ Phone: (____) ____ - _____ o Short-term o Long-term

HEALTH CARE UTILIZATION

1. Overall, how would you rate your health at the present time?
   o Excellent o Good o Fair o Poor o Do not know/Refused

2. During the past 12 months, were you admitted to the hospital for a stay that included at least one night?
   o Yes o No

   If yes, indicate number of times admitted _____ **and** ask the following question.

3. During the past 12 months, how many nights did you spend in the hospital?
   _____ Indicate # of nights o Do not know/Refused

4. During the past 12 months, how many trips did you make to the emergency room? (respondent as patient)
   _____ Indicate number of trips o None (skip to question 6) o Do not know/Refused (skip to question 6)

5. What was the main reason you went to the Emergency Room (if more than one visit, ask about most recent visit, one response only)?
   o Medical Condition was Serious o No Other Source of Medical Care Was Available When Needed
   o Referred by Health Professional/Caregiver o Do not know/Refused
   o Other (Record Reason:) _____

6. How many **primary care doctor** visits (your main doctor, not including specialists) did you have during the past 12 months?
_____ # of visits o None o Do not know/Refused

7. During the past 12 months, how many doctor visits did you have with **specialist(s)** (doctors other than your primary care doctor)?
   _____ Indicate number of visits o None o Do not know/Refused

8. During the past 12 months, did you receive a flu shot?
   o Yes o No o Do not know/Refused

9. How long ago was your last doctor visit?
   o During the past 60 days o During the past 3 to 12 months o Between 1 and 2 years ago
   o 2 to 4 years ago o More than 4 years ago o Never seen a doctor o Do not know/Refused

10. During the past year, were you ever **unable** to see a doctor when you needed to?
   o Yes o No (skip to question 12) o Do not know/Refused (skip to question 12)

11. If you were unable to see a doctor when you needed to, was it because of (check all yes responses):
   o Cost too much o Lack of transportation o Could not get appointment
   o Doctor would not accept Medicaid o Limited hours of service o Other reason o Do not know/Refused

12. During the past 12 months, were you admitted to a nursing home? (all levels of care)
   o Yes o No

   If yes, indicate number of admissions _____ and indicate # of nights_____ o Do not know/Refused

13. Overall, how satisfied are you with the quality of the medical care you received during the past year?
   o Very satisfied o Somewhat satisfied o Somewhat dissatisfied
   o Very dissatisfied o Do not know/Refused

14. Are finances a factor in obtaining adequate health/medical care? o Yes o No

15. Is transportation a factor in obtaining adequate health/medical care? o Yes o No