Peace
Senior Care

Comprehensive Patient Intake Form

Client Information:

Full Name:_____

Date of Birth: _____

Gender: Female

SSN (Optional): _____

Primary Language: _____

Phone Number: _____

Email Address: _____

Current Address:

_____

_____

Primary Contact / Responsible Party:

Full Name: _____

Relationship to Client:_____

Phone Number:_____

Email Address:_____

Preferred Contact Method:_____

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Senior Care

Medical History:

Primary Diagnosis:

_____

_____

Other Diagnosed Conditions:

_____

_____

Allergies: _____

History of Falls: No

Mental Health Diagnoses:

_____

_____

Current or Recent Hospitalizations:

_____

_____

Current Medications:

Medication Name / Dosage / Frequency:

_____

_____

_____

Peace Senior Care

Pharmacy Name & Phone: _____

Care Needs:

Mobility: Bed-bound

Transfer Assistance: Yes

Toileting Assistance: Yes

Incontinence Care: Yes

Bathing Assistance: Yes

Dressing Assistance: Yes

Feeding Assistance: Yes

Special Equipment (e.g., Oxygen, CPAP): Yes

Memory & Cognitive

Diagnosis of Dementia / Alzheimer's: Alzheimer's

Level of Disorientation: Severe

Behavioral Concerns: _____

Wanders or Exit-Seeking Behavior: Yes

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Living Preferences

Preferred Type of Care: _____

Preferred Location / City: _____

Faith or Religious Preferences: _____

OK with Pets: Yes

Private or Shared Room Preference: No Preference

Preferred Activities:

_____

_____

Financial Information

Monthly Care Budget: _____

Source of Payment: Other

Power of Attorney:

_____

_____

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Senior Care

Emergency Contact

Name: _____

Relationship: _____

Phone: _____

Email: _____

Additional Notes of Requests

_____

_____

_____

_____

_____