**HEEBEE HOME CARE 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: ___ Marion ___ Hendrick ___ Johnson ___ Hamilton ___ Hancock ___ 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 ___Yes Veteran? ___ 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 ___ Snap___ 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**

Area:_____ Service(s):_____

Service Provider:_____

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Client Name: _____

**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<br>(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:

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Client:: _____

**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) | | | | |

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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
   - Bathroom
   - Outside the home
   - Between the bed & the bathroom
   - Kitchen
   - Other:

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

Client Name:_____

## MEDICAL CONDITIONS

What are your medical problems? ( use the following codes to answer) Height: _____

1 - had previously 2 - under control

3 - has currently/being treated 4 - has currently/ not being treated 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?<br><br>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)<br><br>PA**IN LEVEL:** _____ | |
| Other | | | | Obesity | | | |
| No problem | | | | Chronic pain | | | |
| | | | | Other | | | |
| | | | | No problem | | | |

Client Name:_____

**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