Medical Information:

When did you last see a doctor? ________________________________ Who?____________________________

Druggist____ Phone ______________________________________

Dentist ____ Phone ______________________________________

Medications

Name	Amount	Frequency	Prescribing Doctor

Presenting Medical Problem and Medical History: (Physical condition and background including illnesses or complaints relevant to present situation)____

____

____

Any History of T.B.? ___________________ T.B. test or chest x-ray within last 6 mos_________________

Any special medical problems: Ulcers, Sores, Eye Discharge, Infections, Feeding Tubes, Catheters, etc.____

____

____

If young Adult Contact person ____

Any hospitalization in last 3 yrs? ________________ Reason____

Any Nursing home placements___________________ Reason____

Are you now considering nursing home placement____

Evaluate Client functioning in terms of(Comment on each item)

Hearing_______________________ Hearing Aid_________________________ Vision___________________

Glasses____________________ Ambulation Schedule____________________ Dental ___________________

Condition_______________________________ Prostheses____

Pacemaker___________________________ Continence__________________ B.R. Schedule?_____________

Special Needs____________________________________ Orientation________________________________

Bath or Shower at Center ? ____

Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL's)

ADL's	No Help	Supervision	Hands On	**IADL's**	No Help	Supervision	Hands On
Transfer/ Mobility	1	2	3	Med Admin	1	2	3
Bathing	1	2	3	Shopping	1	2	3
Grooming	1	2	3	Meal Prep	1	2	3
Dressing	1	2	3	Telephone	1	2	3
Toileting	1	2	3	Arrange Transportation	1	2	3
Eating/Feeding	1	2	3	Ability to take Short walks	1	2	3
Taking Meds	1	2	3	Light Housework	1	2	3
Notes				Laundry	1	2	3
				Heavy Housework	1	2	3
				Home Maintenance	1	2	3
				Legal/Financial	1	2	3

Nutritional risk Assessment(self-declared) Circle yes or no – enter score	Yes	No
I have an illness or condition that made me change the kind and/or amount of food I eat	2	0
I eat Fewer than 2 meals a day	3	0
I eat few fruits or vegetables or milk products	2	0
I have 3 or more drinks of beer, liquor or wine almost every day	2	0
I have tooth or mouth problems that make it hard to eat	2	0
I don't always have enough money to buy the food I need	4	0
I eat alone most of the time	1	0
I take 3 or more different prescribed or over the counter drugs a day	1	0
Without wanting to, I have lost or gained 10 pounds in the last 6 months	2	0
I am not always physically able to shop, cook and/or feed myself	2	0
0-2=Low; 3 to 5= Moderate; 6 or more=High Total		

Psycho-Social Information:
Birthplace ______________________________________ Primary Language spoken at home__________________

Marital Information ____

Sibling Information ____

Names of Children	Address	City/State	Phone #

Religious Preference:___________________________Education: Highest Grade Completed__________________

Any Specialized Training____

Work History____

Veteran/Branch of Service____

Any contact with a mental health professional____

Name:____

Any recent losses(person, functions) or changes in life situation or other stressful life events?

____

Activities Information:
Client's hobbies, interests, skills____

____

What activities, memberships, interests has the client enjoyed in the past__________________________________

____

What particular activities would client like to participate in at the Center?_________________________________

____

Limitations:____

Circumstances related to application for adult day services____

____

Description of Applicant____

Program Plan: Recommended goals for clients should reflect what the client wants to get out of the program; changes he/she wants to make; problems he/she wants to work on. Should include specific services planned with the client; for example, social needs and health needs (including rehab therapies), resource linakage

____

Release Form

In the event of an emergency as determined by the attending staff of the __________________ Center, I agree

to being transported to the closest hospital, and to any other procedures followed on my behalf that may be deemed reasonably necessary by attending staff.

I understand and accept the conditions of participation in the _______________________ as explained to me by

the social worker and in the Client and Family Brochure. This brochure includes emergency numbers for the

_________________________ in the event that I need them.

I permit the _________________________ to transport me from the Center location for special activities such as outings, field trips, shopping trips, etc.

I permit the _____________________________________ to use photographs taken of me and/or quotations

made by me in the publicity of the _______________________. Further, I will allow filming by

television/video cameras of activities in which I participate at the ____________________________.

I have been informed of the ____________________________ Grievance Procedure and I have received a copy of my Right to File a grievance.

I have been informed that I will be skin tested for TB on my first day at the Center.

I have been informed that a 3 day, non refundable deposit is required if I am paying for services privately.

Date _____________________

Client Signature______________________________

and/or

Caregiver Signature __________________________