Center for Healthy Aging Intake Form

It is important this form is completed prior to the first appointment and by a caregiver rather than the patient.

Pt's First Name: _____ Pt's Last Name: _____ MI ___

Pt's Preferred Name: _____ Pt's Date of Birth: ____/___/_____ Gender: ❑Male ❑Female

Pt's Marital Status: ❑Married ❑Single ❑Separated ❑Divorced ❑Widowed If widowed, how long: _____

Name of Pt's Spouse/Partner:_____

Person completing the form: _____ Relationship:_____

ADVANCE DIRECTIVES	Yes	No	Appointee (if applicable)
Power of Attorney (Financial and/or Medical)			
Health Care Representative			
Physicians Order for Scope of Treatment (POST)			
Living Will			
Life Prolonging Procedures Declaration			
Out of Hospital Do Not Resuscitate Declaration and Order			

Please attach a copy of any advance directive patient has established.

EDUCATION/EMPLOYMENT	Yes	No	Comments
English is a second language			If yes, preferred language:
Interpreter needed			
Military Service (patient and/or spouse)			
Last Grade in School Completed			
Highest level of education or training post high school			
Occupational Background			

LIVING ARRANGEMENTS	Yes	No	Comments/Details
Patient lives alone			
Patient lives with spouse or caregiver			
Patient lives in Assisted Living			
Patient lives in Memory Care			
Patient lives in Long Term Care			
Patient considering a move to a different level of care			

SOCIAL SUPPORT	Level of Involvement**	Age	Primary Phone	Secondary Phone	May we contact?	
Involved Caregiver's Name*					Yes	No

*Please list all children regardless of involvement and include any community support/hired care.

**Please list the number of times per week that this individual has contact with patient (by phone or in person).

For additional space use other side of form

Is patient currently receiving services through the local Area Agency on Aging? (i.e. CICOA, Lifestream, etc.) ❑ Yes ❑ No

Case Manager's name and phone #: _____

_____

GENERAL HEALTH *Does the patient have or have a history of the following conditions?*		Select one of the following		Treatment/Comments
		Yes	No	
Skin Problems	Open Sore			
	Rash			
	Dry Skin			
Sensory Problems	Hearing Problems			
	Use Hearing Aides			
	Blindness			
	Glasses			
	Glaucoma			
	Cataracts			
	Macular Degeneration			
Oral Problems	Loose, Cracked Teeth			
	Loose, Cracked Dentures			
	Choking Episodes			
	Difficulty Swallowing			
	Difficulty Talking			
Respiratory Problems	COPD			
	Asthma			
	Sleep Apnea			
	Shortness of Breath			
	Utilizes O2			
	History of Tuberculosis (TB)			
Heart/ Circulatory Problems	Chest Pain			
	Pacemaker			
	Congestive Heart Failure (CHF)			
	Valve Replacement			
	Swelling of Legs or Ankles			
	High Blood Pressure			
	Other			
Digestion Problems	Ulcers			
	Diarrhea			
	Constipation			
	Hemorrhoids			
	Bowel Incontinence			
	Indigestion/Heartburn			
Diabetes	Managed with Diet/Exercise			
	Oral Medication or Insulin Required			
Urinary System Problems	Prostate Problems			
	Prone to Urinary Infection			
	Frequency			
	Dribbling			
	Urinary Incontinence			
	Nighttime Urination			
	Kidney Stones			
Muscle/Joint Problems	Arthritis			
	Fibromyalgia			

GENERAL HEALTH-Continued		Select one of the following		Treatment/Comments
		Yes	No	
Nervous System Problems	Epilepsy			
	Stroke			
	TIA			
	Headaches			
	Dizziness			
	Tremor			
	Parkinson's			
	Forgetfulness			
	Peripheral Neuropathy			
	Other			
Mobility/Falls	Unsteady			
	Stiff/Rigid Walking			
	Shuffling			
	Fall history			
Dietary Concerns	Recent Weight Loss			How much?
				Over what period of time?
	Recent Weight Gain			How much?
				Over what period of time?
	Change in Appetite			
	Difficulty Chewing			
	Difficulty Swallowing			
	Special Diet			Specify:
	Adherent with Diet Order			
	Appetite (circle): Fair Good Poor			
	Number of 8oz. glasses of non-caffeinated fluid per day:			
Mental Health	Anxiety			
	Depression			
	Bipolar Disorder			
	Hallucinations			
	Delusions			
	Paranoia			
	Other:			Specify:
	Hospitalization Related to Mental Health			Provider:
				When:
	Outpatient Treatment			Provider:
				When:
Personal Habits	Currently Smoke			Packs per day:
	History of Smoking			How many years of smoking?
				How many years quit?
	Alcohol Use			Amount:
				Frequency:
	Caffeine Use			Amount:
				Frequency:
	Guns in the home			

GENERAL HEALTH-Continued 2		Select one of the following		Treatment/Comments
		Yes	No	
Sleep Habits	Sleeps through the night			
	Nap during the day			
	Difficulty going to sleep			
	Difficulty staying asleep			

Surgical History _____

Have you ever had a CT or MRI scan of the brain? ❑ Yes ❑ No
Date of scan: ____/____/____ Where did you have this done:_____

Have any family members been diagnosed with dementia or Alzheimer's Disease? ❑ Yes ❑ No
Please list (include immediate and extended family): _____

MEDICAL PROVIDERS Name	Specialty/ Reason for Visit	Date of Last Visit	Phone/Address

FAMILY HEALTH HISTORY *Include Parents, Brothers & Sisters* Family Member	Relationship	Health Problems	Age at Death	Cause of Death

FUNCTIONAL ABILITY ACTIVITIES OF DAILY LIVING		Select one of the following:				
		Does without help	Needs some hands-on help or verbal reminders	Cannot perform safely or correctly without ongoing help	N/A – never has done this task	The need for assistance in this area has increased over time
Self-Care	Able to choose and change appropriate clothing					
	Able to get to the toilet, undress, perform toileting hygiene, and dress again					
	Able to make it to the bathroom without urinary and/or bowel incontinence					
	Able to use the shower, soap, and bathe properly					
	Able to get up from bed or chair					
Domestic	Able to do simple household chores (dust/vacuum, wash dishes, make bed)					
	Able to use the telephone without help (send/receive calls)					
	Can answer the phone but cannot make a call					
	Able to plan for and cook meals					
	Able to wash, dry and fold laundry					
Instrumental Activities	Able to pay monthly bills					
	Able to make sound financial decisions					
	Able to manage medications accurately					
	Able to plan and shop for groceries/household items					
	Able to answer safety questions appropriately (i.e. what would you do if there was a fire?)					
	Able to drive a car/ Currently driving					