CLIENT INTAKE FORM

K&K Legacy Home Care LLC
Client Information

Client Full Name: _____

Date of Birth: _____

Gender: _____

Social Security Number (Optional): _____

Home Address: _____

City: _____ **State:** _____ **ZIP:** _____

Primary Phone: _____

Secondary Phone: _____

Email Address: _____

Emergency Contact Information

Primary Emergency Contact Name: _____

Relationship to Client: _____

Phone Number: _____

Alternate Phone Number: _____

Address: _____

Authorized Representative (If Applicable)

Name: _____

Relationship to Client: _____

Phone Number: _____

Email Address: _____

Referral Information

How did you hear about our agency?

☐ Family/Friend

☐ Social Worker

☐ Physician

☐ Internet Search

☐ Hospital

☐ Community Organization

☐ Other: _____

Living Arrangement

☐ Lives Alone

☐ Lives with Spouse

☐ Lives with Family

☐ Assisted Living

☐ Other: _____

Service Needs

Please check all services requested:

☐ Personal Care Assistance

☐ Transportation Assistance

☐ Companion Care

☐ Mobility Assistance

☐ Meal Preparation

☐ Respite Care

☐ Medication Reminders

☐ Grocery Shopping / Errands

☐ Light Housekeeping

☐ Safety Supervision

☐ Other: _____

Preferred Schedule

Days Needed:

☐ Monday

☐ Tuesday

☐ Wednesday

☐ Thursday

☐ Friday

☐ Saturday

☐ Sunday

Preferred Hours: _____

Requested Start Date: _____

Health Information

Primary Physician: _____

Physician Phone Number: _____

Primary Diagnosis/Health Conditions:

_____

Allergies:

_____

Mobility Status

☐ Independent

☐ Uses Cane

☐ Uses Walker

☐ Uses Wheelchair

☐ Bedbound

☐ Requires Assistance

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Communication Needs

☐ No Special Needs

☐ Vision Assistance Required

☐ Hearing Assistance Required

☐ Language Assistance Required

☐ Other: _____

Safety Concerns

Please identify any known safety concerns:

☐ Fall Risk

☐ Oxygen Use

☐ Memory Impairment

☐ Medical Equipment in Home

☐ Wandering Risk

☐ Other: _____

Insurance Information (If Applicable)

Insurance Provider: _____

Policy Number: _____

Group Number: _____

Additional Notes

_____

_____

Client Acknowledgment

I certify that the information provided on this Intake Form is accurate and complete to the best of my knowledge.

Client Name: _____

Client Signature: _____

Date: _____

Agency Use Only

Date Intake Received: _____

Received By: _____

Assessment Scheduled: _____

Admission Approved: ☐ Yes ☐ No

Service Start Date: _____

Administrator Signature: _____

Date: _____