CLIENT INTAKE QUESTIONNAIRE

Silver Sage
HOMECARE

CLIENT INTAKE FORM
And Questionaire

Complete this form to help your Carer understand your individual needs, preferences, and circumstances. All information is confidential and used solely to provide personalized care.

CLIENT INFORMATION

Client Name | Date of birth

Mobile number

Email address | Work Number

Preferred contact method ☐ Phone ☐ Text ☐ Email

Home address:

Preferred Contact Method:

☐ Call ☐ Text ☐ WhatsApp

☐ Email ☐ Letter ☐ Other _____

Name of Partner/Support Person

Contact name: | Email:

Phone | Address:

EMERGENCY CONTACT

Name Their relationship:

Mobile number

Email address | Work Number

Preferred contact method ☐ Phone ☐ Text ☐ Email

Home address:

Authorized to make medical decisions in case of emergency? ☐ Yes ☐ No

HEALTH & MEDICAL INFORMATION

Primary care provider:

Date of last hospital admission

Clinic/Hospital Name: Contact Number:

Known Allergies:

Current Medications/Supplements:

Medical Conditions (check all that apply):

☐ Arthritis ☐ Dementia/Memory loss ☐ Heart disease

☐ Diabetes ☐ Stroke recovery ☐ Other

If other, please specify:

Medical Conditions	Current Medications (include dosage & frequency)

CLIENT REPRESENTATIVE

☐ Client manages their own care ☐ Care arranged by family member

☐ Care arranged by legal representative

MEDICATION INTAKE INFORMATION

☐ Client manages medication independently ☐ Requires medication reminders

☐ Requires assistance with medication

☐ Medication supplied in blister pack/dosette box ☐ Medication delivered by pharmacy

MOBILITY & PHYSICAL SUPPORT

Mobility Level: ☐ Independent ☐ Uses walking aid

☐ Wheelchair user ☐ Requires assistance

Aids Used (check all that apply):

☐ Walker ☐ Cane ☐ Hoist

☐ Wheelchair ☐ Stairlift

History of falls in the last 12 months: ☐ No

☐ Yes, (details)

PERSONAL CARE NEEDS (Check all that apply)

☐ Washing / bathing ☐ Dressing ☐ Toileting

☐ Continence care ☐ Grooming ☐ Oral hygiene support

☐ Skin care ☐ Nail care (basic) ☐ Shaving and hair care

☐ Other _____

Preferred times for personal care:

Gender preference for carer (if any):

☐ Male ☐ Female ☐ No preferance

DAILY ROUTINES & PREFERENCES

Typical daily routine (wake-up, meals, bedtime):

Additional information:

Food preferences / dietary requirements:

☐ No special diet ☐ Gluten free ☐ Dairy free
☐ Vegitarian ☐ Vegan ☐ Other

Likes, dislikes, hobbies, interests:

COGNITIVE & EMOTIONAL WELLBEING

Food preferences / dietary requirements:

☐ No cognitive concerns ☐ Memory loss ☐ Dementia diagnosis
☐ Anxiety / low mood ☐ Other

How does the client communicate best?

☐ Verbal ☐ Hearing aid ☐ Visual aids
☐ Other

HOME ENVIRONMENT & SAFETY

Please tick where we will be visiting the client

☐ House ☐ Apartment ☐ Condo

How will we be accessing the home?

Will we be keeping a key on hold? ☐ Yes ☐ No

Is there a house alarm, if so please provide the code? ☐ Yes ☐ No

Will their be pets in the home, if so what and temperment? ☐ Yes ☐ No

Does anyone smoke in the home? ☐ Yes ☐ No

CARE REQUIREMENTS

Type of care required ☐ Short term ☐ Long term ☐ Respite care

Preferred visit times:

Days care required:

☐ Monday ☐ Tuesday ☐ Wednesday

☐ Thursday ☐ Friday ☐ Saturday

☐ Sunday

CONSENT & DATA PROTECTION

☐ I consent to the Agency collecting and storing my personal data for care purposes.

☐ I consent to information being shared with healthcare professionals where necessary.

ADDITIONAL NOTES & CONSIDERATIONS

Please provide any additional information you feel we should know:

DECLARATION

I confirm that the information provided in this form is accurate to the best of my knowledge and understand that it will be used to assess and plan care services.

Client name Date

Client signature

Carer Name Date

Carer signature