🏠 Client Intake Form

Alpha Homecare Services
Compassionate Care • Dignified Living • Professional Excellence

📌 1. Client Demographics

- **Full Name:** _____
- **Date of Birth (MM/DD/YYYY):** _____
- **Gender:** _____ **Pronouns:** _____
- **Home Address:** _____

  City/State/ZIP: _____
- **Phone (Primary):** _____ **Alternate:** _____
- **Email:** _____
- **Preferred Contact Method:** ☐ Phone ☐ Email ☐ Text
- **Best Time to Contact:** _____

🆘 2. Emergency & Family Contacts

Name	Relationship	Phone	Alternate Phone
_____	_____	_____	_____
_____	_____	_____	_____

🩺 3. Healthcare Providers

- **Primary Care Physician:** Name: _____

  Phone: _____

  Address: _____
- **Other Providers (Specialists, Nurses, Therapists):**
  1. _____ Phone: _____
  2. _____ Phone: _____
  3. _____ Phone: _____

🧠 4. Medical & Mental Health History

Check all that apply and provide any notes.

☐ Diabetes ☐ Arthritis ☐ Dementia/Alzheimer's ☐ Cardiac Issues ☐ Stroke ☐ COPD ☐ Depression/Anxiety ☐ Vision/Hearing Impairment ☐ Other: _____

Recent Hospitalizations/Surgeries: _____

🦽 5. Activities of Daily Living (ADLs)

Check needed level of support per task.

Task	Independent	Needs Assistance	Dependent
Bathing / Showering	☐	☐	☐
Dressing / Grooming	☐	☐	☐
Toileting & Hygiene	☐	☐	☐
Walking / Mobility	☐	☐	☐
Transfers (e.g., bed/chair)	☐	☐	☐
Feeding	☐	☐	☐

🧭 6. Cognitive & Behavioral Status

- Orientation: ☐ Oriented to Person ☐ Place ☐ Time
- Memory: ☐ Good ☐ Mild ☐ Severe
- Mood / Behavior Notes: _____

🥗 7. Nutrition & Diet

- Diet Type: ☐ Regular ☐ Diabetic ☐ Low Salt ☐ Pureed ☐ Other: _____
- Food Allergies / Restrictions: _____
- Cultural / Religious Preferences: _____
- Meal Assistance Needed: ☐ Yes ☐ No Comments: _____

💊 8. Medications

Medication Name	Dosage	Frequency	Prescriber	Self-Administers ☐ / Needs Help ☐
_____	_____	_____	_____	☐ / ☐
_____	_____	_____	_____	☐ / ☐
_____	_____	_____	_____	☐ / ☐

🏠 9. Home Environment & Safety

- Residence: ☐ House ☐ Apartment ☐ Assisted Living
- Stairs: ☐ Yes ☐ No Pets: ☐ Yes ☐ No (Type: _____)
- Smoking: ☐ Yes ☐ No Safety Concerns: _____
- Equipment at Home: ☐ Walker ☐ Cane ☐ Wheelchair ☐ Hospital Bed ☐ Oxygen

💔 10. Care Preferences

- Caregiver Gender Preference: ☐ Male ☐ Female ☐ No Preference
- Preferred Language: _____
- Religious / Cultural Considerations: _____
- Favorite Activities / Interests: _____

📅 11. Service Schedule

Day	Start Time	End Time	Notes
Monday	_____	_____	_____
Tuesday	_____	_____	_____
Wednesday	_____	_____	_____
Thursday	_____	_____	_____
Friday	_____	_____	_____
Saturday	_____	_____	_____

Day	Start Time	End Time	Notes
Sunday	_____	_____	_____

💳 12. Insurance & Billing

- Payment Source: ☐ Private Pay ☐ Medicaid ☐ Medicare ☐ Insurance
- Carrier Name: _____
- Member ID: _____ Group #: _____
- Authorization #: _____

✍️ 13. Consent & Signature

By signing below, I authorize Alpha Homecare Services to provide non-medical caregiving as outlined. I have reviewed my rights and understand Agency policies.

- **Client/Representative Signature:** _____ Date: _____
- **Printed Name & Relationship:** _____
- **Care Coordinator Signature:** _____ Date: _____