Best at Home

CLIENT INTAKE FORM

Full Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Street Address: _____ City/State: _____

ZIP Code: _____ Email Address: _____ Phone: _____

** EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship: _____

Email Address: _____ Phone: _____

** PLEASE ANSWER THE QUESTIONS BELOW

How did you hear about us? _____ Are there animals in your home? ☐ Yes ☐ No

Are you a smoker? ☐ Yes ☐ No Are you on any medication? ☐ Yes ☐ No

If yes, list them here: _____

_____

** PLEASE MARK ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU CURRENTLY HAVE

- ☐ Alzheimer's Disease or Dementia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Diabetes
- ☐ Depression
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Vision Impairment
- ☐ Other: _____

By signing below, the client understands that accurate and truthful completion of this form is crucial for providing the best possible in-home caregiving services tailored to their specific needs and medical conditions.

Signature: _____ Today's Date: _____