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Information Sheet for Personal Care Client

Referred by: _____ Contact Number: _____

Client Name: _____ Age: _____ Birthdate: _____
Social Security: _____ Home Phone: _____ Mobile Phone: _____
Address: _____

Parent/ Guardian: _____ Contact Number: _____
Address: _____
Primary Caregiver: _____ Relationship to client: _____
Address: _____ Contact Number: _____
Emergency contact: _____ Relationship to client: _____
Address: _____ Contact Number: _____

Primary Physician: _____ Contact Number: _____
Address: _____
Pharmacy: _____ Contact Number: _____
Address: _____ Med Plan #: _____

Allergies:_____

Any Medical Conditions? _____

_____

	Good	Fair	Poor	Comments
Eyes	☐	☐	☐	
Ears	☐	☐	☐	
Nose	☐	☐	☐	
Heart	☐	☐	☐	
Lungs	☐	☐	☐	
Neck	☐	☐	☐	
Back	☐	☐	☐	
Arms	☐	☐	☐	
Legs	☐	☐	☐	
Knees	☐	☐	☐	
Mobility	☐	☐	☐	

Overall Client's Health: _____☐ Good _____☐ Fair _____☐ Poor

Medications Currently Taking? _____

_____

Diet Restrictions: _____

Does the client have any allergies? {_}Yes or {_} No If yes, please list all allergies and allergic reactions:

_____

_____

Does the client take any medications? {_} Yes or {_} No If yes, please list all medications with dose and frequency:

_____

_____

Does the client have any nutritional needs? {_} Yes or {_} No If yes, please list all of them:

_____

_____

Does the client have an Advanced Directive or Living Will? {_} Yes {_} No or {_} No not Resuscitate If other please identify:

_____

If yes, has the client provided their physician with a copy of the Advanced Directive or Living Will?
{_} Yes or {_} No

Is there anything we should know about the client that is pertinent to the client's care and the welfare of our staff? If yes, please describe briefly: _____

_____

Please list requested services: _____

_____

Request received by:

_____

ITN Representative

Request made by:

_____

Signature & Date