

SARAHCARE INTAKE ASSESSMENT FORM

Participant Information

First Name	Middle	Last Name
_____	_____	_____
Date of Birth	Gender	SSN
_____	_____	_____
Address	Apt	
_____	_____	
City	State	ZIP
_____	_____	_____

Demographics

Place of Birth	Nationality	Race
_____	_____	_____
Primary Language	Other Languages	Religion
_____	_____	_____
Marital Status	Military Service	Former Profession/Occupation
_____	_____	_____

Emergency Contacts

Name	Relationship	Phone	Phone 2	Email
_____	_____	_____	_____	_____
Name	Relationship	Phone	Phone 2	Email
_____	_____	_____	_____	_____
Name	Relationship	Phone	Phone 2	Email
_____	_____	_____	_____	_____
Name	Relationship	Phone	Phone 2	Email
_____	_____	_____	_____	_____

Primary Physician

Name	Specialty	Phone	Fax
_____	_____	_____	_____

Insurance Information

Medicare ID	Medicaid ID
_____	_____
Primary Insurance	Policy ID
_____	_____
Secondary Insurance	Policy ID
_____	_____

ALLERGIES

Medication Allergies	Food Allergies	Environmental Allergies
_____	_____	_____

Activities of Daily Living

Activity	Independent	Supervision	Min Assist	Mod Assist	Max Assist
Bathing	<input type="checkbox"/>				
Dressing	<input type="checkbox"/>				
Toileting	<input type="checkbox"/>				
Transferring	<input type="checkbox"/>				
Feeding	<input type="checkbox"/>				
Grooming	<input type="checkbox"/>				

Mobility & Safety

Ambulation:
 Independent With Device Wheelchair Assist Needed

Assistive Devices:
 Walker Cane Wheelchair Other

Fall Risk:
 Low Moderate High

Nutrition

Diet:
 Regular Diabetic Low Sodium Renal Other

Texture:
 Regular Soft Chopped Pureed

Food Likes _____ **Food Dislikes** _____

Social Profile

Help us understand their personality and preferences

Personality _____ **Communication Style** _____

Interests & Hobbies _____

Preferred Activities _____

Activities to Avoid _____

Calming Strategies _____ **Behavioral Triggers** _____

Personal Background

Family Dynamics (# Children, Grandchildren, Siblings, Pets)

Any other memorable information about your loved one:

