Adult Day Center Intake Screening

Date_____

Part I: Personal Information
Name:
Nickname:
Address, Town, and Zip Code:

Phone:
Height:
Weight:
Eye Color:
Hair Color:
Sex: _____M _____F
Birthdate:
Age:
SS# xxx-xx-
Marital Status:
Spouse's Name:
Identifying Marks:

Responsible Party
Name:
Address, Town, and Zip Code:

Relationship:
Phone:
Cell:

Financial Responsible Party
Name:
Address, Town, and Zip Code:

Relationship:
Phone:
Cell:

Emergency Contact #1
Name:
Address, Town, and Zip Code:

Relationship:
Phone:
Cell:

Emergency Contact #2
Name:
Address, Town, and Zip Code:

Relationship:
Phone:
Cell:

Part II: Legal Status
Is there any one person authorized to make decisions under a power of attorney or a legal guardian?
If yes, who/relationship:
Do you have a living will or advanced directive?
If yes for either question, we need a copy for our file.

PART III: Referral
How did you hear about the Adult Day Center?
Reason for wanting to attend the Adult Day Center?
If you are determined eligible, how many days per week are you interested in coming to the center?
Which Days? Sun Mon Tue Wed Thurs Fri Sat

PART IV: Living Arrangements and Transportation
Living Arrangements: Spouse_____ Child _____ Other, specify _____
Type of Dwelling: House _____ Apartment _____ Other, specify _____

Adult Day Center Intake Screening

Circle: Lives with someone Lives alone

Present Address:

What transportation you will use to get to and from the Center?

Does the applicant carry a house key? _____ If yes, can applicant be left at home alone? _____

PART V: Family and Social History

Birthplace:

Father's Name: Mother's Name:

Names of living brother and/or sisters:

Names of deceased brothers and/or sisters:

Names of living children:

Names of deceased children:

What was the highest grade in school you completed?

Are you a veteran, spouse of a veteran, parent of a veteran? (Circle one) What branch? _____

What was/is your main occupation?

What was your worst job?

Circle activities of potential interest.

Arts and Crafts	Bingo	Cards
Physical Games	Music/Choir	Table Games
Exercise	Pet Therapy	Socializing
Plant Care	Read Newspaper or Magazine	Other: _____
Sensory/Mental Stimulation	Bible Study	

Is applicant comfortable being in the company of non-family members? _____

What is one of your best skills?

PART VI: Medical Information and Health History

Diagnosis:

Primary Doctor:

Address, Town, and Zip Code:

Phone:

How would you rate your own health?

Current Medical Problems:

Past Medical Problems:

Date of last hospitalization:

Where:

Reason:

Do you have diabetes? How is it controlled? Oral medications? Injection? Diet?

Do you have seizures? _____ If yes, explain: _____

Adult Day Center Intake Screening

Are you allergic to any medications? _____ If yes, explain: _____

Are you allergic to any environmental allergens? _____ If yes, explain: _____

Can the applicant self-administer medications?

Medications: Be sure to include over the counter medications.

Medication	Dosage	Time/Frequency

PART VII: Medical Contacts

Other physicians, CRNP (include names and phone number):

Preferred Hospital:

Preferred Medical Transport Company:

PART VIII: Caregiving

What other community agencies (home health or social service) do you currently use or have used?

Agency	Reason

Do you have a care manager?

Are there other caregivers besides the responsible party listed on the front page? _____

If yes, please list: Relationship:

Limitations, problems, or restraints on primary caregiver?

What is the extent of the perceived burden on the caregiver(s)?

Does the caregiver feel the need for support? If yes, explain:

Adult Day Center Intake Screening

PART IX: ADLs, IADLs, and Physical Aids

Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)

Levels of Assistance:

0 = Independent – Completes task independently
1 = Minimum Assistance – Occasional assistance or supervision may be necessary
2 = Moderate Assistance – Assistance or supervision is always needed
3 = Maximum Assistance – Totally Dependent on other

Activity	Ind 0	Min Assist 1	Mod Assist 2	Max Assist 3	Primary Source of Help	Comments
Mobility						
Transferring						
Bathing						
Grooming						
Personal Hygiene						
Eating						
Toilet Use						
Meal Preparation						
Laundry						
Shopping						
Light Housework						
Home Maintenance						
Telephone						
Financial Management						
Transportation						

Adult Day Center Intake Screening

Medical Devices Used:

Walker	Cane	Wheelchair	O_2
Prosthetics	Glasses	Hearing Aid	Dentures
Hospital Bed	Catheter	Feeding Tube	Ostomy
Other:			

Notes about devices used:

PART X: Nutrition

Special Diet? If yes, explain:
Appetite: Good Fair Poor
Allergies to any foods? If yes, list:
How many meals are consumed in a day? 1 2 3 Snacks
Chewing or swallowing problems?
Troublesome foods? If yes, explain:
Are there any special instructions for meal times?

PART XI: Cognitive/Behavioral Status

Is the applicant oriented to Person? Yes No
Place? Yes No
Time? Yes No
Is the applicant's recent (short term) memory: Good Fair Poor
Is the applicant's distant (long term) memory: Good Fair Poor
What is your favorite family vacation memory?
Is the applicant able to understand verbal directions? Yes No
Is the applicant able to communicate needs (thirst, bathroom, hunger, etc.)? Yes No
If yes, how?
Is the applicant able to understand written directions? Yes No
Is the applicant aware of danger, risks, and consequences? Yes No
Any recent stressful events? If yes, describe:

What is the applicant's response to illness?

Circle any behaviors the applicant has experienced:
depressed anxious paranoid aggressive agitated withdrawn
suicidal thoughts other:

Is the applicant receiving any mental health treatment? If yes, describe:

Is the applicant experiencing any current emotional problems or related behaviors such as wandering or sleeplessness? If yes, describe:

Adult Day Center Intake Screening

Part XII: Optional

Religious Affiliation:

Is there a need for additional services (available for a fee)? Shower Shave Podiatrist

What is one thing you wish people knew about you?

Any other notes or concerns:

Form completed by: _____

Name and Title

With: _____

Name and Relationship

Applicant meets the criteria for admission: Yes No

If no, has applicant received written notice within 30 days of completion of intake screening?