CLIENT INTAKE FORM
CALL-A-SERVICE INC./HARMONY HALL CENTRE FOR SENIORS

DATE _____ **Referred by:** _____ **Client #** _____

Male Female

_____ _____
First Name **Last Name**

_____
Street Name **Apt.#** **Postal Code**

_____ _____
Telephone Number **Date of Birth**

LIVES ALONE **yes** **no** **spouse/other family/other**

WHEEL TRANS **yes** **no**

HEALTH

Mobility Aid? Cane Walker Wheelchair **Eyesight vg g limited blind**

Hearing vg g limited deaf

Physician's name and phone number: _____

Health Card Number (optional) _____

Does this person have any *SERIOUS* medical problems, e.g. diabetes, heart problems, breathing problems, etc.

_____

_____

OTHER INFORMATION

OTHER HOME SUPPORT AGENCIES INVOLVED?, i.e. caregiver

_____ _____
Agency Name **Telephone #**

EMERGENCY CONTACT

_____ _____
Name **Telephone #** **Relationship**

Additional Information: _____

_____

_____

Revised May 2008