



Customer Assessment Form

Name:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address:		Primary Language:	
City, State, Zip:		Advance Directives:	DNR:
DOB:	Phone:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Location:	Location:

Primary Contact:		Relationship:	
Address:		Home Phone:	Cell Phone:
City, State, Zip:		Business Phone:	

Secondary Contact:		Relationship:	
May Assist in care decisions:		Home Phone:	Cell Phone:

Physician Name:		Type of Physician:	Phone:
Address:		Preferred Hospital:	
City, State, Zip:		Hospital Phone:	

Has Home Health: <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospice: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Healthcare Providers:	
Provider:	Provider:	Contact Name:	
Other:	Hospice Phone:	Policy #:	Phone#:
Phone#:			

Medical History			Provide with Customer and family input the Customer's history of physical condition related to daily activities:		
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Arthritis	<input type="checkbox"/> HIV / Aids			
<input type="checkbox"/> Blood Pressure Issues	<input type="checkbox"/> Breathing Issues	<input type="checkbox"/> Cancer			
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Dementia	<input type="checkbox"/> Diabetes			
<input type="checkbox"/> Falls / Balance	<input type="checkbox"/> Hearing Issues	<input type="checkbox"/> Heart Issues			
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Memory Issues	<input type="checkbox"/> Paralysis			
<input type="checkbox"/> Seizures	<input type="checkbox"/> Speaking Issues	<input type="checkbox"/> Stroke			
<input type="checkbox"/> Tremors	<input type="checkbox"/> Vision Issues	<input type="checkbox"/> Wounds			
Allergies:	Other:	Recent Surgery:			

Supportive Devices								
Device	Uses	Needs	Device	Uses	Needs	Device	Uses	Needs
Ambulatory			Bedside Commode			Cane		
Dentures			Emergency Response System			Furniture Raised		
Glasses			Grab Bars in Bathroom			Hand Held Shower		
Hearing Aid			Hospital Bed			Lift Chair		
Mobility Cart			Oxygen			Raised Toilet Seat / Arm Rest		
Ramps			Shower Chair / Bench			Stair / Bed Rails		
Transfer Board			Walker			Wheelchair		
Other:								

ALL INFORMATION OBTAINED PER CLIENT AND OTHER RESPONSIBLE PARTIES

Activities Form

Date: ____/____/____

Customer Name: _____

Estimated Weekly Schedule: _____

Estimated Start Date: _____

*Client may change schedule at any time.

Companionship and Homemaking

Description	Instructions	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Per Request
Supervision / Companionship									
Prepare Breakfast									
Prepare Lunch									
Prepare Dinner									
Prepare Snacks									
Light Housekeeping									
Laundry									
Change Bed Linens									
Cleaning Kitchen									
Cleaning Bathroom									
Water Plants									
Oversee & Assist with Ambulation									
Correspondence with Family									
Respite Care for Family									
Water/Walk/Feed Pets									
Transportation									
Shopping/Errands/Activities									
May leave client to run errands									
May not leave client to run errands									
Medication Observations									

Personal Care

Description	Instructions	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Per Request
Routine Hair & Skin Care									
Dressing									
Grooming – Hygiene, Makeup									
Transfer or Ambulation									
Showering or Stand-by Assistance									
Toileting – Chair and/or Depend									
Oral Care: Teeth and/or Dentures									

Activities developed with Client / Family Input

Customer Signature: _____

Date ____/____/____

Agency Signature: _____

Date ____/____/____

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