LIFE Enhancements HOME HEALTH CARE, LLC

Initial Client Assessment Questionnaire

Name: _____

DOB: _____

Gender: _____

Diagnosis:_____

Facility or location prior to home care need: _____

Reason for admittance to prior facility:

Brief reason for in-home care at this time:

Is client alert and oriented?_____

If no, briefly explain clients confusion.

_____

Days and hours (time frames) of care needed:

_____

Anticipated amount of funds allocated toward home care each month?_____

Insurance coverage_____

Does the client live alone?_____

If no, with whom does the client reside?_____

Is client incontinent of bowel or bladder? _____

Is client able to feed him/herself: _____

Is client able to transfer him/herself from bed to chair? _____

Devices used at this time (wheelchair, walker etc.): _____

Home aid preference (male/female): _____

Support system (son, daughter, etc.):
_____

Contact information for responsible/consulting party:

Name:_____

Relationship: _____

Phone _____