Your Life. Your Home. Our Help.

INTAKE QUESTIONNAIRE

Name: ______________________________ Nickname: _______________________

DOB: __/__/____ Age: _______

Address: ____

____

____

Phone: __________________________

Email:___________________________

Do You Live Alone? Yes ___ No___

If No, Please Provide the Contact Information For the Person you Live With?

Name____

Phone____

Email____

Relationship_____________________________________

Who is Your Emergency Contact?

Name____

Phone____

Email____

Relationship_____________________________________

EDUCATIONAL BACKGROUND

What is the highest degree of level of school you have completed?

- High School
- Trade/technical/vocational training
- Some College Credit, no degree
- Associate Degree
- Bachelor's Degree
- Master's Degree
- Professional or Doctorate Degree

What type of profession are/were you employed?

____

Did you serve in the Armed Forces? Yes____ No____

UPBRINGING

Siblings: Yes____ No____ Brothers: ______ Sisters: _______

WHAT FAMILY SUPPORT DO YOU HAVE?

Children: ______ Grandchildren: ______
Do they live in the Grand Traverse region? Yes____ No____

NEIGHBOR SUPPORT

Do you have a neighbor you could call in an emergency? Yes____ No____
If yes, please provide their Name and Phone Number:

____

How often do you see family members or friends?

Daily
Weekly
Monthly
At the Holidays
Rarely

Do you have any pets? Yes____ No____ — Dog____ Cat____Other___________

What is Your Church/Religious Affiliation *(if any):*

____

Ethnic Origin: Please specify your ethnicity

White

Latino

African American

Native American

Asian/Pacific Islander

Other_____________

Please List any Special Considerations We Should Know About?____

Are you affiliated with any other organizations for services *(please list)*?
____
____
____

Have you ever volunteered with ShareCare? Yes___No____

Are you interested in volunteering? Yes____ No______

How do you like to relax? ____
____

What is most important to you in maintaining your health and happiness?
____
____

Who is Your Primary Doctor:____

Are there other doctors that you see on a regular basis? For example, a neurologist, urologist, endocrinologist or cardiologist? (Please list):
____
____
____
____

Please Check Any of the Following Medical Conditions that Apply to You.

Vision

- Corrective Lenses
- Macular Degeneration
- Glaucoma
- Cataracts

Hearing

- Hearing Loss
- Hearing aids

Other

Loss of Smell
Loss of Taste
Dentures
Incontinent
Substance Use/Abuse

Please List Your Current Medications:
____
____
____

Do You Have Chronic Pain? Yes____ No____

If Yes, Where Do You Experience Chronic Pain?:
____

What Surgeries Have You Had, if Any?:
____

Do You Have Any Mobility Challenges? Yes___No____

Have You Had Any Recent Falls? Yes_____ No____

Do You Use Any Assistive Devices *(check all that apply)*

Cane
Walker
Wheelchair
Grab Bars
Removable Showerhead
Shower Chair
Shower Bench
Toilet Riser

What Therapies Do You Utilize? (check all that apply)

Psychological Support
Physical Therapy- *How Often:* ______________________________
Occupational Therapy- *How Often:* _________________________
Massage
Chiropractic
Acupuncture/pressure

What is Your Daily Routine?

Time Awake: ___________

Do you require someone to wake you? yes___ no___

Do you eat each of the following meals?

Breakfast: yes___ no___

Lunch: yes___ no___

Dinner: yes___ no___

Do you nap? yes___ no___

Time Asleep:____________

How often do you feel lonely or sad?

Never

Rarely

Sometimes

Often

Do you feel safe in your home? Yes___ No____

How often do you feel overwhelmed?

Daily

Weekly

Every So Often

Never

Do You Require Any Assistance With Any of the Following Activities? *(check all that apply)*

Dressing

Bathing

Meal Prep

Medications

Transportation

Laundry

Dishes

Lawn Care

Snow Removal

What chores do you do currently and what do you no longer do, if any?

Still do: ____

No longer do: ___________________________________

Do You Still Drive? Yes_____ No_____:

What Activities Do You Most Enjoy?_________________________________

What is Your Favorite Music? _______________________________________

Do you Attend Social Events? Yes___No____

If yes, what types of social events do you attend? ____________________

Which of Following Do you Have in Your Home: *(check all that apply)*

Landline phone
Cell phone
Internet
Computer
Smoke Detectors
Carbon Monoxide Detector
Generator
Stairs to an Upstairs or Basement
Steps into Home
Ramps
Decks
Narrow Doorways
Area rugs
Clutter

Do you Stay in Leelanau County in the Winter? Yes____ No_____

If No, Please Provide the Approximate Dates You are NOT Here
From __________ To________________

How can ShareCare best support you?

____

For Office Use (SERVICES ASSESSMENT)

Volunteer Services: (check all that apply)

- Transportation
- Grocery Pickup and delivery
- Prescription Pickup and Delivery
- Phone Reassurance Program
- Friendly Visitor
- Spring Yard Clean Up
- Fall Yard Clean Up
- Meals
- Minor Home Repair
- Pet Care (emergencies only)
- Technology Assistance
- Family Caregiver Program
- Respite

Staff Services: (check all that apply)

- RN Home Visit
- Memory Loss Support Group
- Educational & Wellness Workshops
- Specific Requests:____
- Durable Medical Equipment

Agency Referrals: (check all that apply)

- LCSS
- Area Agency on Aging
- Commission on Aging
- Pace North
- Fire Dept
- Home Care
- Facility