Adult Family Care Home Pre-Intake Form

Compassionate Assisted Living in a Place That Feels Like Home

1. Resident Information

Full Name: _____

Date of Birth: _____ Age: _____

Gender: ☐ Male ☐ Female ☐ Other

Phone Number: _____

Email Address: _____

Current Address: _____

2. Primary Contact / Responsible Party

Name: _____

Relationship: _____

Phone Number: _____

Email Address: _____

3. Health & Medical Information

Primary Care Physician: _____

Physician Phone Number: _____

Current Diagnosis / Medical Conditions:

_____

_____

Allergies: ☐ None ☐ Yes (list): _____

Taking Medications: ☐ No ☐ Yes If yes, how many: _____

4. Insurance & Benefits Information

☐ Medicare ☐ Medicaid ☐ VA Benefits

☐ Long-Term Care Insurance ☐ Private Pay

☐ SSI ☐ SSDI

Insurance Provider: _____

Policy / ID Number: _____

5. Care Needs Assessment

☐ Bathing ☐ Dressing ☐ Grooming ☐ Toileting

☐ Mobility / Transfers ☐ Eating ☐ Medication Assistance

Additional Care Needs:

_____

6. Social & Lifestyle Interests

Hobbies / Interests: _____

Preferred Activities / Social Outings: _____

7. Dietary Restrictions

Dietary Restrictions / Preferences: _____

Signature: _____

Date: _____