**KHOBCARE CLIENT INTAKE FORM - Client Information**
**Information Provided by: ____ Client _____ Other**

Last Name:_____ First Name:_____ MI:_____

Gender: M F DOB:_____/_____/_____ SSN:_____ DCN:_____

Address:_____ City:_____ Zip:_____

Phone Number:_____ Living Alone: Y N

County: Tulare- Fresno- Kings- Kern or _____

**Marital Status:** Single Married Divorced Partnered Widowed

Primary Language: ____ English /Spanish or other: _____ Care Provider Gender Preference: _____

**Legal Status:**

Responsible for Self Power of Attorney Guardian Name:_____

Phone Number:_____

**Eligibility:**

Age:_____

**Veteran:** Yes No Branch: Discharge Date Spouse/Widow of Veteran? Yes No

**Ethnicity:** Hispanic/Latino Not Hispanic/Latino

African-American Am. Indian/Native Alaskan Asian Native

Hawaiian/Pacific Islander White Other:

Citizenship Status

___ US Citizen
___ Permanent Res.

**Income:** Subsidized/Low-Income Housing Medicaid SSI Food Stamps Low Income Other:

**Primary Emergency Contact:**

Name:_____ Aware they are emergency

contact? Y N Home Number:_____ Work Phone:_____

Relationship:_____ Cell Number:_____

Email:_____

Address:_____ City:_____ Zip:_____

**Second Emergency Contact:**

Name:_____ Aware they are emergency

contact? Y N Home Number:_____ Work Phone:_____

Relationship:_____ Cell Number:_____

Email:_____

Address:_____ City:_____ Zip:_____

**Service Information**

KHOBCARE Service Area:_____
Service(s):_____
Client Name: _____

**Referral Information**

Abuse/Neglect -Adult Day Care - Advocacy Animal Services- Case Mgmt - Caregiver Services- Property Tax Credit -

**Nutritional Status**

| | Yes | Comment |
|---|---|---|
| I have an illness or condition that made me change the kind/amount of food I eat. | 2 | |
| I eat fewer than 2 meals per day. | 3 | |
| I eat a few fruits, vegetables, or milk products. | 2 | |
| I have 3 or more drinks of beer, liquor, or wine almost everyday. | 2 | |
| I have tooth or mouth problems that make it hard for me to eat. | 2 | |
| I don't always have enough money to buy the food I need. | 4 | |
| I eat alone most of the time. | 1 | |
| I take 3 or more different prescribed or over-the-counter drugs a day. | 1 | |
| Without wanting to, I have gained or lost 10 pounds in the past 6 months | 2 | Change: |
| I am not always physically able to shop, cook or feed myself. | 2 | Which: |
| Total score for each Yes response<br>(0-2: low risk; 3-5 moderate risk: 6 or more high risk) | | Risk level: |

Client :_____
Signature Date: _____

Intake Worker:_____
Signature Date Referral Source: Telephone Number: _____

Notes:
Client:: _____

**FUNCTIONAL ASSESSMENT**

**Levels of Assistance:**
**0 = Independent** - Completes the task independently
3 = Minimum Assistance -Occasional assistance or supervision may be necessary
6 = Moderate Assistance - Assistance or supervision is always necessary
9 = Maximum Assistance - Totally dependent on others
1. For each activity check the box indicating the assistance needed.
2. If assistance is needed, indicate the source of help (**be specific: spouse, family, friend, paid help, volunteer, professional)** 3. In the comments section indicate the type of assistance provided and how often it is provided. Also indicate if the client needs further help.

**ACTIVITIES OF DAILY LIVING**

| **Activity** | **Ind 0** | **Min. Assist 3** | **Mod. Assist 6** | **Max Assist 9** | **Primary Source of Help** | **Comments / Other Sources** |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| Eating | | | | | | |
| Bathing | | | | | | |
| Grooming | | | | | | |
| Dressing | | | | | | |
| Toilet Use | | | | | | |
| Mobility | | | | | | |
| Transferring | | | | | | |

**INSTRUMENTAL ACTIVITIES OF DAILY LIVING**

| **Activity** | **Ind 0** | **Min. Assist 3** | **Mod. Assist 6** | **Max Assist 9** | **Primary Source of Help** | **Comments / Other Sources** |
|---|---|---|---|---|---|---|
| Laundry | | | | | | |
| Shopping | | | | | | |
| Light Housework | | | | | | |
| Heavy Housework | | | | | | |
| Telephone | | | | | | |
| Financial Management | | | | | | |
| Transportation | | | | | | |
| Meal Preparation | | | | | | |
| Medication Management | | | | | | |

| **Adaptive Equipment** | **Has** | **Has, Does Not Use** | **Needs** | **Comments** |
|---|---|---|---|---|
| Bathing Equip ( bath bench, grab bars, etc) | | | | |
| Brace (leg, back) prosthesis | | | | |
| Cane, Crutches, Walker | | | | |
| Diabetic Supplies | | | | |
| Dentures | | | | |
| Railings | | | | |
| Hospital Bed | | | | |
| Medical Phone Alert | | | | |
| Toilet Equipment (ie, raised commode) | | | | |
| Wheelchair (manual, power) | | | | |

| | | | | |
|---|---|---|---|---|
| Other (specify) | | | | |

Client Name:_____

**HOUSEHOLD CONVENIENCES**

| | Client Has | Client Needs | Observation: Does the client's home have health and safety issues related to any of the following? | | |
|---|---|---|---|---|---|
| Electricity | | | General repair of home exterior | | |
| Gas, Propane | | | Yard Condition | | |
| Heating System (type?) | | | Sidewalk, exterior stairs | | |
| Air Conditioner (window or central) | | | Exterior Lighting | | |
| Fan | | | Odors (urine, garbage, pets) | | |
| Flush Toilets | | | General Repair of Home Interior | | |
| Tub, Shower | | | Interior Clutter | | |
| Piped water, hot/cold | | | Interior Lighting | | |
| Stove, hotplate, oven, toaster oven | | | Room Temperature | | |
| Can opener (electric or manual) | | | Accessibility of Phone(s) | | |
| Microwave | | | Food Storage | | |
| Blender | | | Accessibility of fire exits and smoke detectors | | |
| Radio, television | | | Bugs or rodents inside home | | |
| Refrigerator | | | Accessibility of emergency phone numbers | | |
| Telephone | | | | | |
| Washer | | | Unsafe Pathways | | |
| Dryer | | | Pets | | |
| Comments: | | | No Problems | | |

**PLACE OF RESIDENCE**

What floor does the client live on?_____ Is the bathroom on the same floor? Yes No If the client lives on other than the main floor: Is there an elevator, lift or stair lift? Yes No Number of steps to enter the home?_____ Are steps a problem within the home? Yes No

Ask the Client the following: Do you have difficulty getting into your home? Yes No Do you have difficulty getting into any room in your home? Yes No

Comments:

**FALL RISK SCREENING** (ask the client the following questions)

1. How many times have you fallen in the past year?_____

2. Are you worried you might have a fall? Not at all A little Somewhat Very 3. Do you limit activities now because of fall-related concerns? Never Occasionally Sometimes Often

If the client has NOT fallen in the past year, skip questions 4 & 5 below.

4. Where have you fallen?

Getting in & out of bed Bathroom Outside the home
Between the bed & the bathroom Kitchen Other:

5. Can you say what makes you more likely to fall?

Feeling dizzy/lightheaded Getting up too quickly Walking in darkness Certain Shoes Turns Walking on certain surfaces Stairs Dim Lighting Other:



**MEDICAL CONDITIONS**

What are your medical problems? ( use the following codes to answer) Height: _____ 1 - had previously 2 - under control
3 - has currently/being treated 4 - has currently/ not being treated Weight: _____

| **Category** | **Code** | **Category** | **Code** | **Category** | **Code** | **Category** | **Code** |
|---|---|---|---|---|---|---|---|
| **Cardiovascular** | | **Hearing/Vision** | | **Respiratory** | | **Skin** | |
| Ankle edema | | Deaf | | Asthma | | Pressure/other ulcer | |
| By-pass surgery/ Angioplasty | | Hearing deficit | | COPD | | Rashes | |
| Chest pain | | Hearing aid | | Cough (dry/productive) | | Shingles | |
| Circulation problems | | Hearing Other | | Difficulty breathing | | Stasis dermatitis | |
| Congestive heart failure | | Hearing No Problem | | Emphysema | | Other | |
| Heart attack | | Blind | | Oxygen | | No problem | |
| Hypertension | | Blurred Vision | | Bronchitis | | **Genitourinary** | |
| Hypotension | | Cataracts | | Pneumonia | | Dialysis | |
| Pacemaker | | Glaucoma | | Other | | Difficulty/frequent urination | |
| Shortness of breath | | Macular Degeneration | | No Problem | | Dribbling / incontinence | |
| Other | | Vision Other | | | | Frequent bladder infections | |
| No problem | | Vision No Problem | | | | Nighttime urination/ Nocturia | |
| **Endocrine** | | **Infectious Disease** | | | | Other | |
| Diabetes | | AIDS | | | | No Problem | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Thyroid | | HIV positive | | | | | |
| Other | | Hepatitis | | | | **Neurological** | |
| No problem | | Tuberculosis | | | | Alzheimer's disease | |
| | | Other | | | | Cerebral Palsy | |
| **Gastrointestinal** | | No Problem | | **Other** | | CVA/Stroke | |
| Abdominal pain | | | | Reduced Physical Stamina | | Dementia | |
| Colitis | | **Musculoskeletal** | | Dehydration | | Dizziness | |
| Constipation | | Amputation of: | | Allergies - food/ medicine | | Paralysis of: | |
| Diarrhea | | Arthritis - rheumatoid or osteo | | Anemia | | Parkinson's Disease | |
| Difficulty swallowing | | Back pain | | Autism | | Seizures/epilepsy | |
| Diverticular disease | | Contractures | | Cancer | | Multiple Sclerosis (MS) | |
| Frequent use of laxatives | | Fracture of: | | Developmental disability | | Amyotrophic lateral sclerosis | |
| Gallbladder problems | | Joint replacement of: | | Depression | | Other | |
| Indigestion | | Polio/Post Polio | | Drug use/abuse | | No Problem | |
| Irritable bowel syndrome | | Other | | Mental retardation | | **PAIN** | |
| Ulcers | | No problem | | Tobacco use | | Are you in pain now? | |
| Other | | | | Obesity | | If yes, rate your level of pain on a scale of 1 - 10 (1 indicates no pain, 10 indicates the most intense level of pain) | |
| No problem | | | | Chronic pain | | | |
| | | | | Other | | PA**IN LEVEL:** _____ | |
| | | | | No problem | | | |



**MEDICAL PERSONNEL**

Primary Doctor: _____ Phone Number (____) ____ - _____

Other In-home provider name: _____ Phone: (____) ____ - _____ o Short-term o Long-term

**HEALTH CARE UTILIZATION**

1. Overall, how would you rate your health at the present time?
   o Excellent o Good o Fair o Poor o Do not know/Refused

2. During the past 12 months, were you admitted to the hospital for a stay that included at least one night?
   o Yes o No

   If yes, indicate the number of times admitted _____ **and** ask the following question.

3. During the past 12 months, how many nights did you spend in the hospital?

_____ Indicate # of nights o Do not know/Refused

4. During the past 12 months, how many trips did you make to the emergency room? (respondent as patient) _____ Indicate number of trips o None (skip to question 6) o Do not know/Refused (skip to question 6)

5. What was the main reason you went to the Emergency Room (if more than one visit, ask about the most recent visit, one response only)?
o Medical Condition was Serious o No Other Source of Medical Care Was Available When Needed o Referred by Health Professional/Caregiver o Do not know/Refused
o Other (Record Reason:) _____

6. How many **primary care doctor** visits (your main doctor, not including specialists) did you have during the past 12 months?
_____ # of visits o None o Do not know/Refused

7. During the past 12 months, how many doctor visits did you have with **specialist(s)** (doctors other than your primary care doctor)?
_____ Indicate number of visits o None o Do not know/Refused

8. During the past 12 months, did you receive a flu shot?

o Yes o No o Do not know/Refused

9. How long ago was your last doctor visit?
o During the past 60 days o During the past 3 to 12 months o Between 1 and 2 years ago
o 2 to 4 years ago o More than 4 years ago o Never seen a doctor o Do not know/Refused

10. During the past year, were you ever **unable** to see a doctor when you needed to?
o Yes o No (skip to question 12) o Do not know/Refused (skip to question 12)

11. If you were unable to see a doctor when you needed to, was it because of (check all yes responses):
o Cost too much o Lack of transportation o Could not get appointment
o Doctor would not accept Medicaid o Limited hours of service o Other reason o Do not know/Refused

12. During the past 12 months, were you admitted to a nursing home? (all levels of care)
o Yes o No

If yes, indicate number of admissions _____ and indicate # of nights_____ o Do not know/Refused

13. Overall, how satisfied are you with the quality of the medical care you received during the past year?
o Very satisfied o Somewhat satisfied o Somewhat dissatisfied
o Very dissatisfied o Do not know/Refused

14. Are finances a factor in obtaining adequate health/medical care? o Yes o No

15. Is transportation a factor in obtaining adequate health/medical care? o Yes o No

Client Name:_____ Date:_____

Representative Name:_____ Date:_____

Title:_____

Was this done via ZOOM/PHONE? Yes or No

Was the client notified that the conversation was being recorded? Yes or No

Does the client know that completing this contract form for services that they're legally binded to the contract until CLIENT OR

KHOBCARE terminate services. And services must be terminated with a week in advanced notice? Yes or No

Clients are notified that they can't offer individual providers fees for services as this will go against our contract and we have the right to seek legal counsel?

Clients are aware that all of our providers are insured/bonded, background checked and CPR certified? Yes or No

Clients, Will like to start services effective on: _____ From: _____ Time:_____

**Note: SSN SHOULD BE ADDED ONLY IF INSURANCE INFORMATION IS BEING USED FOR MEDICAL COVERAGE**

Representative Signature: _____ Date: _____