ELDER INTAKE FORM

TODAY'S DATE_____ REFERRAL SOURCE_____

LAST NAME_____ FIRST NAME_____ MI_____

DATE OF BIRTH_____ MALE ____ FEMALE____ VETERAN ___YES ___NO

STREET ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____ PHONE NUMBER _____
SINGLE ____MARRIED ____ DIVORCED/SEPARATED ___WIDOWED ___ WIDOWER____

SPOUSE'S NAME_____ SPOUSE'S DATE OF BIRTH _____

NAME OF EMERGENCY CONTACT (1)
_____PHONE_____

NAME OF EMERGENCY CONTACT (2)

_____PHONE _____

PRIMARY LANGUAGE ENGLISH___ TRIBAL___ OTHER_____

HOUSING ___ HOUSE ___ APARTMENT __COMMUNITY HOUSING __OTHER EXPLAIN_____

COMPOSITION ___ LIVES ALONE ___ LIVES WITH SPOUSE ___LIVES WITH FAMILY/FRIENDS

___OTHER EXPLAIN _____

NUMBER IN HOUSEHOLD _____ WHO HELPS _____

HEALTH HISTORY ___ ASTHMA ___ALZHEIMER'S ___ARTHRITIS ___CANCER ___DEMINTIA

___DIABETES ___CHRONIC PAIN ___HEARING AID ___CHOLESTEROL ___BLOOD PRESSURE

PRIMARY TRANSPORTATION ___Own Car ___Friend ____Public Trans. ___Senior Tran's __Family

PROSTHETIC DEVIECS ___ Walker/Cane__Wheelchair ___Hearing Aid ___Glasses __Dentures ___None

ARE YOU ENROLLED WITH A DIFFERENT TITLE VI PROGRAM? ____ YES ____ NO

IF YES, NAME OF PROGRAM & WHERE LOCATED:_____

HEALTH CONCERNS _____

SERVICES CURRENTLY BEING RECEIVED _____