HEALTH BRIDGE
HOMECARE

New Client Intake Form

Client Information

Full Name: _____

Date of Birth: _____

Gender: _____

Address: _____

City: _____ Postal Code: _____

Phone Number: _____

Email: _____

Health Card Number (Optional): _____

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Email: _____

Primary Physician

Doctor's Name: _____

Clinic Name: _____

Phone Number: _____

Medical Information

Diagnosis / Medical Conditions:

_____

Allergies:

_____

Current Medications:

_____

Mobility Status:

☐ Independent

☐ Uses Walker

☐ Wheelchair

☐ Bedridden

☐ Requires Full Assistance

Cognitive Status:

☐ Alert & Oriented

☐ Memory Loss

☐ Dementia

☐ Alzheimer's

Care Services Required

☐ Personal Care (Bathing, Dressing, Grooming)
☐ Toileting Assistance
☐ Medication Reminders
☐ Companionship
☐ Light Housekeeping
☐ Meal Preparation
☐ Respite Care
☐ Post-Hospital Recovery
☐ Overnight Care

Preferred Schedule:
Days: _____
Hours: _____

Home Safety Assessment (Non-Medical)

☐ Fall Risk Present
☐ Stairs in Home
☐ Pets in Home
☐ Smoking in Home
☐ Special Equipment Needed

Notes:

_____

_____

Consent & Agreement

I consent to receive non medical home care services from Health Bridge Homecare. I understand that services provided are supportive and do not replace medical treatment.

Client/Representative Name: _____

Signature: _____ Date: _____