Personal History

Please take your time and complete as much of this form as you are able. Return it to us in advance or have it available for your appointment. The information you give us will help us understand you better and identify all the services that may be helpful to you.

Current Date: _____

1. Client Information

Client Name: _____ Date of Birth: _____
Telephone Number(s): Home:(____)_____ Cell: (____)_____ Other: (____)_____
Address 1: _____
Address 2: _____
Client Email: _____
Citizenship: _____
Race/Ethnicity: _____
City/Country of Birth: _____
Primary Language: _____
Secondary Language: _____
Marital Status: _____

Veteran or Spouse of Veteran: ☐ **Yes** ☐ **No**

2. Is there a Conservator in Place? ☐ **Yes** ☐ **No**

Conservator's Name: _____
Conservator's Phone Number(s): Home: (____)_____Cell: (____)_____Other: (____)_____
Conservator's Address 1: _____
Conservator's Address 2: _____
Conservator's City, State, Zip: _____
Conservator's Email: _____

3. Is there a Guardian in place? ☐ **Yes** ☐ **No**

Guardian's Name: _____
Guardian's Phone Number(s): Home: (____)_____Cell: (____)_____Other: (____)_____
Guardian's Address 1: _____
Guardian's Address 2: _____
Guardian's City, State, Zip:))_____

4. Durable Power of Attorney (DPOA)? ☐ **Yes** ☐ **No**

DPOA Name: _____
DPOA Phone: Home: (____)_____ Cell: (____)_____Other: (____)_____
DPOA Address:_____

Is it active: ☐ **Yes** ☐ **No**

Notes: _____
_____
_____

Personal History

5. **Medical Durable Power of Attorney (MDPOA)?** ☐ **Yes** ☐ **No**

MDPOA Name: _____

MDPOA Phone: Home: (____)_____ Cell: (____)_____ Other: (____)_____

MDPOA Address:_____

Is it active ☐ **Yes** ☐ **No**

Notes:_____

_____

_____

6. **Advance Directive; such as DNR or Code Status?** ☐ **Yes** ☐ **No**

Please Describe: _____

_____

_____

Document Location: _____

Contact Name: _____

Contact Phones: Home: (____)_____ Cell: (____)_____ Other:(____)_____

_____

CONTACT INFORMATION

Primary Contact: _____

Relationship: _____

Telephone Number(s): Home: (____)_____ Cell: (____)_____ Other (____)_____

Address 1: _____

Address 2: _____

City, State, Zip: _____

Email: _____

Notes: _____

_____

_____

Secondary Contact: _____

Relationship: _____

Telephone Number(s): Home:(___)_____Cell: (___)_____Other: (____)_____

Address 1: _____

Address 2: _____

City, State, Zip: _____

Email: _____

Notes: _____

_____

_____

Personal History

Third Contact: _____
Relationship: _____
Telephone Number(s): Home: (____)_____Cell: (____)_____ Other: (____)_____
Address 1: _____
Address 2: _____
City, State, Zip: _____
Email: _____
Notes: _____
_____
_____

SUPPORTIVE SERVICES

1. **Are there any agencies currently providing homecare services?** ☐ **Yes** ☐ **No**

   Caregiver Agency: _____
   Agency Phone: _____
   Caregiver's Name: _____
   Caregiver's Address 1: _____
   Caregiver's Address 2: _____
   Caregiver's City, State, Zip: _____
   Caregiver's Phones: Home: (___)_____ Cell : (___)_____

2. **Other Services Currently in Place?** ☐ **Yes** ☐ **No**

   Agency: _____
   Contact Person: _____
   Address 1: _____
   Address 2: _____
   City, State, Zip: _____
   Phone: Home: (____)_____ Cell: (____)_____
   Email Address: _____
   Fax: _____

3. **Spiritual Support**

   Religious Affiliation: _____
   Place of Worship: _____
   Preferred Funeral Home: _____

   Are there funeral arrangements in place? ☐ **Yes** ☐ **No**

   Is the funeral prepaid: ☐ **Yes** ☐ **No**

MEDICAL INFORMATION

1. **Insurance:**

   Do you have Medicare? ☐ **Yes** ☐ **No**
   Medicare Policy Number: _____
   Prescription Coverage Number: _____

Personal History

Do you have Medicare Part D (prescription coverage)? ☐ **Yes** ☐ **No**

Do you have Medicaid? ☐ **Yes** ☐ **No**

Do you have a supplemental insurance policy? ☐ **Yes** ☐ **No**

If yes, supplemental insurance provider and policy number: _____

_____

2. **Preferred Hospital:** _____
3. **Preferred Pharmacy:** _____

Phone: (____)_____ Fax: (____)_____

Address: _____

4. **Current Presenting Diagnosis:**

Circle the numbers of all items that apply to you now or in the past:

1. Allergies
2. Anxiety
3. Appetite disturbance
4. Asthma
5. Back and neck problems
6. Broken bones
7. Cancer _____
8. Chronic fatigue
9. Chronic Pain _____
10. Circulation problems
11. Dementia/Memory Loss-diagnosed
12. Dementia/Memory Loss-Undiagnosed
13. Depression
14. Diabetes
15. Eating Disorders
16. Frequent falls
17. Hallucinations
18. Head Injury
19. Hearing problems
20. Heart disease _____
21. High cholesterol
22. Hypertension (high blood pressure)
23. Hypoglycemia
24. Incontinence
25. Injury from abuse
26. Insomnia
27. Liver disease _____
28. Low blood pressure
29. Major accidents
30. Major surgery
31. Migraine headaches
32. Neurological conditions_____
33. Pancreatitis
34. Rheumatologic conditions _____
35. Seizure
36. Speech problems
37. Stomach problems _____
38. Thyroid problems _____
39. Unexplained weight gain
40. Unexplained weight loss
41. Vision problems

5. **Allergies:** Medications: _____

Food: _____

Other: _____

☐ No Known Allergies

Personal History

Doctor #1 – Primary Care
Name : _____
Address 1: _____
Address 2: _____
City, State, Zip _____
Phone: (____)_____Fax (____)_____
Email: _____

Doctor #2
Name: _____ Specialty: _____
Address 1: _____
Address 2: _____
City, State, Zip _____
Phone: (____)_____ Fax (____)_____
Email: _____

Doctor #3
Name: _____ Specialty: _____
Address 1: _____
Address 2: _____
City, State, Zip _____
Phone: (____)_____ Fax (____)_____
Email: _____

Doctor #4
Name: _____ Specialty: _____
Address 1: _____
Address 2: _____
City, State, Zip _____
Phone: (____)_____ Fax (____)_____
Email: _____

Doctor #5
Name: _____ Specialty: _____
Address 1: _____
Address 2: _____
City, State, Zip _____
Phone: (____)_____ Fax (____)_____
Email: _____

Personal History

Medication Information

MEDICATION	DOSAGE	FREQUENCY	REASON FOR USE	PRESCRIBED BY

Additional Notes:

_____

_____

_____

_____

_____

_____

_____

Name of person completing form: _____

Relationship to client: _____

Date form completed: _____

7.27.17