100 Mt. Allen Drive
Mechanicsburg, PA 17055
Phone: 717-790-8224
Fax: 717-795-5567

Messiah Lifeways Adult Day Services
Client Intake Assessment

Client Name: _____ Home Phone: _____

Address: _____ Date of Birth: _____

City: _____ Zip: _____

County: _____ Social Security #: _____

Marital Status: _____ Name of Spouse: _____

Veteran: _____Yes _____No Description of Service: _____

Religious Affiliation (optional): _____

Physical Descriptors: Hair Color: _____ Eye Color: _____

Height: _____ Weight: _____ Distinguishing Features: _____

Emergency Contacts: (**Please provide at least 2 and are able to pick client up**)

1. _____ _____
   Name Relationship
   _____
   Address
   _____ _____
   Home Phone Cell or Work Phone
   _____
   Email Address

2. _____ _____
   Name Relationship
   _____
   Address
   _____ _____
   Home Phone Cell or Work Phone
   _____
   Email Address

Advance Directives & Living Will Documentation:

Does Participant Have Any of the Following Documents?

A Living Will/Advance Directive: _____ No _____ Yes, *please provide a copy*

A Health Care Power of Attorney: _____ No _____ Yes, *please provide a copy*

A Financial Power of Attorney: _____ No _____ Yes, *please provide a copy*

A Legal Guardian: _____ No _____ Yes, Name: _____

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Medical Information: *(if additional Specialist, please attach a list)*

Primary Physician Name: _____

Phone: _____

Specialist Name: _____

Phone: _____

Date of Last Hospitalization: _____

Reason for Last Hospitalization: _____

Hospital Preference in case of emergency:_____

Medical Insurance:

Primary Insurance: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

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Service Request:

Indicate days you plan to attend: ___Monday ___Tuesday ___Wednesday ___Thursday ___ Friday

What hours do you plan to attend the program? _____

How did you hear about our Adult Day Service program? _____

Were you referred to our program?_____

Caregiver's Concerns:

Caregivers's goals for client: _____

_____

How Messiah Lifeways Adult Day may be able to help:

_____

_____

Daily Living:

Please indicate level of ability by selecting one of the following numbers for each activity listed below:

Level 1	Independent	Needs no assistance with activity
Level 2	Supervision	Able to physically do all the activity, but needs supervision for safety, confidence, or limited judgement
Level 3	Assistance	Needs assistance to complete activity
Level 4	Dependent	Unable to complete activity without continued assistance

Activity	Level Number	Description of Assistance Needed
Walking		Assistive device used: _____ Unsteady? ☐ No ☐ Yes At risk for falling? ☐ No ☐ Yes Loses Balance? ☐ No ☐ Yes
Transferring to and from chair		☐ Position assistive device ☐ Cue for safety ☐ Minimal assist
Toileting		☐ Incontinent? Urine Bowel How often? _____ Product used: _____ ☐ Needs reminded ☐ Assist in bathroom (describe) ☐ Catheter Colostomy
Eating		☐ Cutting foods/preparing plate ☐ Special utensils ☐ Cuing/Encouragement ☐ Other
Taking Medications		☐ Difficulty swallowing ☐ Resistive
Bathing		
Dressing		
Shopping		
Cooking		
Housekeeping		
Laundry		
Financial Matters		

Comments: _____

Special Devices/Equipment Required:

- ☐ Glasses
- ☐ Contacts (L) (R)
- ☐ Dentures (U) (L) (P)
- ☐ Hearing Aid (R) (L)
- ☐ Indwelling Catheter
- ☐ Standard Walker
- ☐ Rolling Walker
- ☐ Cane
- ☐ Wheelchair
- ☐ Other_____

Functional Status:

VISION: ☐ Good ☐ Large Print ☐ Legally Blind ☐Cataracts: ___

HEARING: ☐ Good ☐ Limited ☐ Deaf (R) (L)

SPEECH: ☐ Clear ☐ Uses Gestures ☐ Aphasic ☐ Non-clear

Arm Function: ☐ Full ☐ Partial (Left) (Right) ☐ None (Left) (Right)

Hand Function: ☐ Full ☐ Partial (Left) (Right) ☐ None (Left) (Right)

Psychosocial Status/Well Being:

Self – Descriptions:

- ☐ Loner
- ☐ Follower
- ☐ Enthusiastic
- ☐ Motivated
- ☐ Apathetic
- ☐ Self-Starter
- ☐ Independent
- ☐ Cooperative
- ☐ Depressed
- ☐ Dwells on Illnesses/other problems
- ☐ Sociable
- ☐ Physically Active
- ☐ Cheerful
- ☐ Uncooperative
- ☐ Leader
- ☐ Optimistic
- ☐ Willing to try
- ☐ Withdrawn

Communication & Cognitive Patterns:

Primary Language: ☐ English ☐ Other:_____

Ability to Understand Others:

☐ Understands ☐ Usually Understands ☐ Rarely/Never Understands

Ability to Read:

☐ Yes ☐ No ☐ Special Accommodations:_____

Attention Span:

What holds the client's attention?_____

Behavior, Cognition & Functional Status:

	Circle One	Comments
Oriented (name, place, date, etc)	YES NO	
Has recent memory	YES NO	
Has distant memory	YES NO	
Has had recent mental health treatment	YES NO	
Understands directions	YES NO	

Is aware of danger	YES NO	
Wanders/Exit Seeks	YES NO	
Need of supervision	YES NO	
Has behaviors/symptoms	YES NO	

Dietary Requirements & Personal Preferences:

Regular Diet ☐ Yes ☐ No

Special Diet: ☐ Diabetic ☐ Mechanical Soft ☐ Limited Liquids
☐ Low Sodium ☐ Soft Foods/Pureed ☐ Encourage Liquids

Special Needs:_____

Food Allergies:_____

Food Likes:_____

Food Dislikes/Not Tolerate: _____

Favorite Beverage or Snack: _____

Educational & Occupational History:

Check highest level of education achieved:

☐ Left school before graduating (What grade? _____)

☐ Graduated from HIgh School (Which School _____)

☐ College or Trade School (Which School _____)

Former Occupation: _____

Clubs or Organizations: (List current or prior memberships)

_____

_____

Social History:

With whom does the client reside? _____

Has there been any changes in living arrangements within the past 2 years? _____

_____

Where did the client live most of their childhood? _____

Where did the client live most of their adult life? _____

Children: (if none, list supportive relatives and friends):

Name	Address	Relationship	Daytime Phone #

Leisure Assessment:

MUSIC PREFERENCES

1. Does the client enjoy listening to music? _____
2. Favorite types of music:
   ☐ Classical ☐ Sacred ☐ Rock/Modern ☐ Jazz
   ☐ Big Band ☐ Country/Western ☐ Old Favorites ☐ Other: _____
3. Does the client enjoy singing? _____
4. Does the client enjoy dancing? _____ Type: _____

LEISURE ASSESSMENT

Please check any current or past interests

ART	CRAFTS	SOCIAL/LEISURE	TRIPS
☐ ceramics	☐ flower arranging	☐ Dancing	☐ Country drives
☐ painting/drawing	☐ sewing	☐ Family dinners	☐ Restaurants
☐ photography	☐ woodworking	☐ Picnics	☐ Parks
☐ art appreciation	☐ knitting/crocheting	☐ Reading	☐ Road trips
☐ coloring	☐	☐ WatchingTV	☐
☐		☐	
TABLE GAMES	**ACTIVE GAMES**	**FITNESS**	**EDUCATIONAL**
☐ Bingo	☐ Bowling	☐ Walking	☐ Discussion groups
☐ Cards	☐ Golf	☐ Armchair fitness	☐ Current events
☐ Board games	☐ Bocce'	☐ Weight lifting	☐ Nature studies
☐ Guessing games	☐ Balloon Volleyball	☐	☐ Health issues
☐ Word searches	☐		☐ Computers
☐ Crossword Puzzles			☐
☐ Puzzles			
RELIGIOUS	**INTERACTIONS**	**GIVING BACK**	
☐ Bible Studies	☐ Children	☐ Volunteering	
☐ Volunteering at Church	☐ Animals	☐ Service Projects	
☐ Choir	☐	☐	

☐			

Other Interest: _____

_____

Transportation:

Usual means of transportation: _____

Provide Phone # if a Public Provider: _____

Community Contact:

Please list any health and/or social services agencies with whom you have had contact within the past 12 months.

Agency Name	Contact Person	Phone #	Reason for Contact

Financial:

Please list the individual(s) to bill for services:

Name: _____Relationship: _____

Address: _____

Home Phone #: _____ Cell #: _____

Long-Term Plans for the Client:

Has the client participated in a Senior Center? ____ Yes ____ No

Is the client on a waiting list at a facility for placement? _____ Yes _____ No

Signature of Responsible Party: _____ Date: _____

Office Use Only:

Recommendations: Applicant is appropriate for Adult Day Services: ☐ Yes ☐ No

Plan:

- ❑ Place on waiting list
- ❑ Applicant undecided: Follow-up date: _____
- ❑ Not Eligible - Reason: _____
- ❑ Declined Services - Date/Reason: _____

Messiah Lifeways Adult Day Team Member who Reviewed:
Name: _____ Date: _____