100 Mt. Allen Drive
Mechanicsburg, PA 17055
Phone: 717.790.8224
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Messiah Lifeways® Adult Day Services

Client Intake Assessment

(Please complete the form in its entirety)

Client Name: _____ Home Phone: _____

Address: _____ Date of Birth: _____

City: _____ Zip: _____

County: _____ Social Security #: _____

Marital Status: _____ Name of Spouse: _____

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 the Participant Have Any of the Following Documents (*If Yes, please provide a copy)*?

- ☐ A Living Will/Advance Directive
- ☐ A Health Care Power of Attorney
- ☐ A Financial Power of Attorney
- ☐ A Legal Guardian (if yes, name) : _____

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

Primary Physician Name: _____

Phone: _____

Specialist Name: _____

Phone: _____

Date / Reason of 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 program?

- □ Word of Mouth
- □ Social Media
- □ Agency Referral: _____
- □ Other: _____
- □ Search Engine (i.e google)

Caregiver and Client Goals:

Caregivers's goals for client: _____

_____

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 #

Transportation:

Usual means of transportation: _____

Provide Phone # if a Public Provider: _____

Psychosocial Status/Well Being:

Self – Descriptions:

- □ Loner
- □ Follower
- □ Enthusiastic
- □ Motivated
- □ Apathetic
- □ Self-Starter
- □ Independent
- □ Cooperative
- □ Depressed
- □ Dwells on Illnesses
- □ 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	
Is aware of danger	YES NO	
Wanders/Exit Seeks	YES NO	
Need of supervision	YES NO	
Has behaviors/symptoms	YES NO	

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 judgment
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		☐ Unsteady? ☐ At risk for falling? ☐ Loses Balance? ☐ Assistive Devices? □ Walker (standard/rolling) □ Wheelchair □ Cane
Transferring to and from chair		☐ Position assistive device ☐ Cue for safety ☐ Minimal assist
Toileting		☐ Incontinent? Urine Bowel Product used: _____ ☐ Needs reminded ☐ Assist in bathroom (describe):_____ ☐ Catheter ☐ Colostomy
Eating		☐ Cutting foods/preparing plate ☐ Special utensils ☐ Cuing/Encouragement ☐ Dentures (U) (L)
Taking Medications		☐ Difficulty swallowing ☐ Resistive

Activity	Level Number	Activity	Level Number
Dressing		Cooking	
Laundry		Housekeeping	

Functional Status:

VISION: □ Good □ Large Print □ Legally Blind □ Cataracts: ___ □ Glasses

HEARING: □ Good □ Limited □ Deaf (R) (L) □ Hearing Aids (L) (R)

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)

Dietary Requirements & Personal Preferences:

Regular Diet □ Yes □ No

Special Diet: □ Carb Control (Diabetic) □ Mechanical Soft □ Limited Liquids
□ No Added Salt □ Pureed □ Encourage Liquids

Food Allergies:_____

Food Likes:_____

Food Dislikes/Not Tolerate: _____

Favorite Beverage (*circle all that apply*): Iced Tea Lemonade Water Coffee Hot Tea Hot Chocolate

Other:_____

Leisure Assessment:

Please Circle any **current (C)** or **past (P)** interests

ART	CRAFTS	SOCIAL/LEISURE	FITNESS
C P painting/drawing **C P** art appreciation **C P** coloring	**C P** flower arranging **C P** sewing **C P** woodworking **C P** knitting/crocheting	**C P** Dancing **C P** Family dinners **C P** Reading **C P** Watching TV	**C P** Walking **C P** Armchair fitness **C P** Dancing Type: _____
TABLE GAMES	**ACTIVE GAMES**	**MUSIC**	**EDUCATIONAL**
C P Bingo **C P** Cards **C P** Board games **C P** Word searches **C P** Crossword Puzzles **C P** Puzzles	**C P** Bowling **C P** Golf **C P** Bocce' **C P** Balloon Volleyball	☐ Classical/Jazz ☐ Sacred ☐ Rock/Modern ☐ Big Band ☐ Old Favorites ☐ Country/Western	**C P** Discussion groups **C P** Current events **C P** Trivia **C P** Nature studies **C P** Health issues
RELIGIOUS	**INTERACTIONS**	**GIVING BACK**	**OTHER INTERESTS**
C P Bible Studies **C P** Church Volunteer **C P** Choir Affiliation: _____	**C P** Animals **C P** Children	**C P** Volunteering **C P** Service Projects	☐ ☐ ☐

Activity Dislikes: _____

Educational & Occupational History:

□ High School *(school name)*: _____

□ College/Degree *(school name)*:_____

□ Technical or Trade School *(school name)* :_____

Former Occupation: _____

Veteran: _____Yes _____No Military Branch:_____

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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 □ Not Eligible - Reason:_____

□ Declined Services- Date/Reason: _____

Messiah Lifeways Adult Day Team Member who Reviewed:

Name: _____ Date: _____