Application for Membership

Date: _____ Referred by: _____

Private pay: **Y / N** Long Term Insurance: _____

Applicant Name: _____ M _____ F _____

Address: _____

Telephone: _____ Email: _____

Date of birth: _____ Marital Status *(circle)*
Married Separated/Divorce Widowed Single

Who do you live with/relation to you? _____

How many hours a week are needed? _____

How many stairs into your home? _____ # of stairs inside your home? _____

Highest level of Education: _____ Current employment Status: _____

Veteran Information

Is applicant a Veteran? Y / N Service Connected? Y / N Spouse a Veteran? Y / N

If yes, Name of VA Center where services received: _____

Address/Phone number: _____

_____

Application for Membership

Next of Kin (Primary Contact)

Name/Relationship: _____

Address: _____

Telephone #: _____ Work #: _____

Is this person your (circle one and please enclose copies as necessary)

Health Care Proxy	Guardian	Conservator
Power of attorney	None of the above	

Medical History

Primary Care Physician & Phone #: _____

Neurologist & Phone #: _____

Current Height: _____ Weight: _____ DNR: *(do not resuscitate)* ☐ Full Code: ☐

Primary Diagnosis and Year Diagnosed: _____

Any other members of your family with similar diagnosis, if yes, who? _____

Please check any symptoms you are currently experiencing

	Visual changes		Changes in sensation		Pain-Where?
	Tremors		Spasticity		Impaired coordination
	Muscle weakness		Impaired balance/dizziness		Bladder or Bowel (circle which one)
	Fatigue		Heat Sensitivity		Changes in speech
	Memory or Cognitive Changes		Falls in the last 6 months How Many _____		Changes in sexual function
	Hearing changes		Swallowing changes		

Have you noticed any changes in the above over the past 6 months? If yes, please describe:

_____

_____

_____

Check the assistive devices you currently use:

	Hearing aids. How many: _____		Glasses – reading, bifocals, contact lenses		Power or manual wheelchair or scooter
	Single point cane		4 point cane		Hemi-walker
	Rolling walker		Standard 4 point walker		Shower Chair
	Tub bench		Commode Chair		Raised toilet seat
	Shower bars		Catheter/Type: _____		Slide Board
	Hoyer lift				

Have you ever been diagnosed with:

a) Diabetes **b)** Arthritis **c)** Hypertension/High Blood **d)** Heart Disease
e) Cancer **f)** Osteoporosis **g)** Depression

Other Medical issues (i.e. diabetes): _____

_____

Do you use tobacco? If yes, indicate type, amount a day and how long used: _____

_____

Do you use alcohol? If yes, indicate type, amount a day and how long used: _____

_____

Have you been hospitalized over the past three (3) years? If yes, please list hospital, how long and reason for hospitalization:

_____

_____

_____

How many emergency room visits have you had in the past 2 years? _____

What consistency of foods and liquids are you eating now? (i.e. Regular, ground, thin, nectar liquids, etc.): _____
_____

Current list of medications - (use back of sheet if necessary)

Medication name & dose	How often, each day and each week	Purpose

All clients are responsible for up-to-date medications

Please describe any medication, food, latex or any other allergies. If none, write "NONE".
_____
_____

Skin Condition

Location of wounds/open sores: _____

Size of wounds/open sores: _____

Type of dressing: _____

How often is dressing changed? _____

PART II – Functional Status

Mobility – the ability to ambulate or use wheelchair to move 50 feet.

A. Ambulates independently, with or without device or in wheelchair (list type of device) _____. No supervision needed
B. Ambulates with hands-off supervision. No risk for falls
C. Ambulates with physical assistance: **minimum moderate maximum** ***(Circle one)***
D. Wheelchair – needs: **minimum moderate maximum** assistance ***(Circle one)***

Chair to chair transfer

A. Independent with transfers
B. Needs **Minimum Moderate Maximum**, assist to transfer ***(Circle one)***
C. Dependent on others. What type of lift: **Mechanical** and/or **2 person** ***(Circle one)***

Stair climbing – ability to climb 7-10 stairs

A. Independent – Able to climb stairs with railing, safely.
B. Need a cane or other assistive device to climb stairs.
C. Need minimal physical assistance of one person to climb stairs
D. Need moderate to maximum physical assistance of one to climb stairs.
E. Unable to perform.

Toileting

A. Continent of bladder and bowel – Able to care for self at toilet.
B. Continent, but with use of device such as Adult briefs, catheter and bag, etc. Please specify type of device: _____.
C. Incontinent
D. No Control over bowel and bladder – dependent for changes.

Eating – Ability to get food/drink from table to mouth using own strength.

A. Eats independently with or without set-up. Using regular or adapted utensils.

B. Needs: **minimum** **moderate** **maximum** physical assistance ***(Circle one)***
C. Needs to be fed by someone.

Medication Management

A. Independently remembers and takes/administers all medications.
B. Needs reminders to take/administer medications but is able to actually take/administer medications independently, once reminded.
C. Can take oral medications independently but is dependent on someone else to administer injections.
D. Dependent on others for medication administration.

Dressing – ability to dress and undress both upper and lower body.

A. Dresses and undresses independently
B. Needs minimum moderate maximum physical assist. (Circle one)
C. Dependent on other to be dressed.

Grooming – the ability to brush teeth, comb hair, shave and or apply cosmetics.

A. Independent – No external assistance needed
B. Independent, with use of adapted devices. List devices: _____
_____.
C. Needs minimal help from someone for one or all tasks.
D. Needs maximum help for one or all tasks.
E. Dependent on other to perform this task.

Vision – able to read newspaper sized print, independently with or without glasses (specify)

A. Independent.
B. Needs larger print, but independent to read large print.
C. Needs VERY large print.
D. Cannot read even very large print.
E. Legally blind.

Speech – able to express needs, wants, ideas easily via spoken word

A. Independent, not speech issues
B. Mildly impaired speech, but does not interfere with communication
C. Impaired speech, slurred or quiet, needs to repeat self to convey message

D. Severe speech impairment is difficult to convey message or uses a communication devise.

Mood and thought problems – include feeling depressed, nervous, anxious, angry outbursts or rapid mood swings.

A. No problem
B. Occasional mood or thought difficulty that does not interfere with daily functioning.
C. Mood or thought problem mildly interferes with daily functioning but is managed with medications and/or assistance from other professionals.
D. Problem moderately/severely interferes with daily functioning and requires medications and professional assistance.

Memory function – includes memory and attention.

A. No problems
B. Mild memory problems that do not interfere with daily functions, or the person is able to use lists and strategies to get things done accurately.
C. Moderate memory issues that cause mild problems on a daily basis – e.g. needs reminder to take medications, etc.
D. Severe memory issues that make the person unsafe to be at home alone.