

**Department of Older Adults Intake Form**

Date: Enter date.

Name: Client Name. Gender: Male Female Didn’t Self Identify

Race:  Client’s Identified Race. Didn’t Self Identify Hispanic/Latino Ethnicity: Yes No

Phone Number: Client Phone Number. DOB: Enter date of Birth. Age: Enter Client Age.

Address: Client Address. City/Zip: Client City and Zip.

**Please Mark One of the Fallowing in Each Category**

**Emergency Contact Information**

Name: Emergency Contact Name.

Relation: Emergency Contact Relation.

Phone Number: Emergency Contact Phone.

**Degree of Visual Impairment:**

Total (LP or NLP)  Legally Blind  Severe Visual Impairment

**Major Cause:**

Macular Degeneration  Diabetic Retinopathy  Glaucoma

Cataracts  Other: Click or tap here to enter text.

**Other Age-Related Impairments:**

Notes:

Enter notes here.

**Pets:** Yes  No

**Type:** Click or tap here to enter text.

Hearing  Mental Health/Mood Disorders

Communication (Expressive/Receptive Communication)

Mobility Impairment (Bone, Muscle, Joint, Parkinson’s, etc.)

Cognitive/Intellectual (Alzheimer’s, Down Syndrome, etc.)

Other Impairments: Click or tap here to enter text.

**Living Arrangement:**

Alone  With Others

**Type of Residence**

Private (House/Apartment)

Senior Independent Living Facility  Assisted Living Facility

Nursing Home/Long Term Care Facility  Homeless

**Source of Referral**

Eye Care Provider Physician/Medical Provider Government or Social Service Agency (Public/Private)

State Department of Rehabilitation Assisted Living Senior Program Veterans Administration

Nursing Home/Long Term Care Facility Independent Living Center Family/Friend Self

Other: Click or tap here to enter text.