

 **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.