

# Continuum Care Collective

# New Client Intake

COMPASSIONATE NON-MEDICAL HOME CARE

Atlanta, Georgia · continuumcarecollective.com

## CLIENT INFORMATION

FIRST NAME

LAST NAME

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DATE OF BIRTH

AGE

GENDER

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HOME ADDRESS

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CITY

STATE

ZIP CODE

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PHONE NUMBER

EMAIL ADDRESS

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## EMERGENCY CONTACT / RESPONSIBLE PARTY

FULL NAME

RELATIONSHIP TO CLIENT

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PHONE NUMBER

EMAIL ADDRESS

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## SERVICES REQUESTED

Check all that apply.

- Personal Care (bathing, grooming, dressing)
- Medication Reminders
- Meal Preparation
- Mobility Assistance
- Respite Care (family relief)

- Companionship & Conversation
- Light Housekeeping
- Transportation & Errands
- Overnight / 24-Hour Care
- Post-Surgical Recovery Support

PREFERRED START DATE

HOURS NEEDED PER WEEK (APPROX.)

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PREFERRED SCHEDULE / DAYS & TIMES

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**HEALTH & BACKGROUND**

Does the client have any diagnosed medical conditions we should be aware of?  Yes  No

IF YES, PLEASE LIST

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Does the client take any regular medications?  Yes  No

Does the client have any allergies (food, medication, or environmental)?  Yes  No

IF YES, PLEASE DESCRIBE

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ANY ADDITIONAL NOTES, PREFERENCES, OR SPECIAL CONSIDERATIONS

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HOW DID YOU HEAR ABOUT US?

- Google Search
- Doctor / Hospital Referral
- Flyer or Mailer
- Referral from Friend or Family
- Social Media
- Other: \_\_\_\_\_

**Authorization & Consent:** By signing below, I authorize Continuum Care Collective LLC to collect and use the information provided in this form for the purpose of arranging non-medical home care services. I understand that this intake form does not constitute a binding service agreement and that a separate care plan and service contract will be provided prior to care beginning.

SIGNATURE OF CLIENT OR RESPONSIBLE PARTY

DATE

\_\_\_\_\_

PRINTED NAME

\_\_\_\_\_

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Continuum Care Collective LLC

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