CTEMS Wellness 🗹’s ℠

 Initial Intake Form

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Level of Service (Please Circle): Weekly, Bi Weekly, Tri Weekly Visits

Subscriber Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Initial Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff Member Completing Assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| **Questions** | **Notes** |
| Is English your primary language?❒ Yes❒ NoIf not English, what is your primary language? |  |
| Does the subscriber want or need an interpreter during home visits?❒ Yes❒ No |  |
| What is the subscriber’s health problem of greatest concern?  |  |
| Who is your primary caregiver?  |  |
| If someone other than the subscriber is the primary caregiver, what is their name and phone number? |  |
| Do you see a Dr regularly? If not, why?❒ Yes❒No |  |
| When you were at the Dr last, did you understand everything your Dr told you?❒ Yes❒ No |  |
| Where do you usually go for medical care?❒ Primary Care Physician (PCP)❒ Specialist❒ Emergency Room❒ Urgent Care Center❒ Other |  |
| Who is the PCP that treats you? |  |
| Do you allow us to contact them to share information about our visits?❒ Yes❒ No |  |
| When did you last see your PCP? |  |
| Do you need assistance scheduling your medical appointments?❒ Yes❒ No |  |
| Do you need assistance getting to your appointments?❒ Yes❒ No |  |
| How do you usually get to your appointments, if you don’t have issues?❒ Drive Self❒ Walk❒ Public Transportation❒ Friend or Relative❒ Access/ NAMS/Senior Transport |  |
| **Questions** | **Notes** |
| In general, how would you rate your health?❒ Excellent❒ Very Good❒ Good❒ Fair❒ Poor |  |
| In the past year, how many times did you visit the emergency room for yourself?❒ 1 time❒ 2-3 times❒ More than 3 times? |  |
| What did you go to the emergency room for? |  |
| In the past year, how many times were you admitted to the hospital? ❒ 1 time❒ 2-3 times❒ More than 3 times |  |
| Why did you get admitted to the hospital? |  |
| Have you ever been told that you have any of the following conditions?❒ HTN ❒ Kidney Failure❒ High Cholesterol ❒ Stroke❒ Asthma ❒ Back Pain❒ Diabetes ❒ Memory Problems❒ Heart Failure ❒ Other❒ Heart Disease ❒ None❒ Sickle Cell❒ COPD/Emphysema❒ Cancer |  |
| **Questions** | **Notes** |
| How many different prescription medicines do you take on a daily basis? (Count the number of different medications, not the number of pills you take.) |  |
| Do you understand why your medications have been prescribed to you?❒ Yes❒ No |  |
| Do you understand how to take your medications?❒ Yes❒ No |  |
| In the past week, how often have you taken your medicines as prescribed?❒ All the Time❒ More than Half the Time❒Half the Time❒Less than Half the Time❒ Not at All |  |
| Do you have any problems obtaining your medications?❒ Yes❒ No |  |
| If you have difficulty, what makes it difficult to take your medications as prescribed?❒ Cost❒ Forget to take❒ Side Effects of medications❒ Transportation❒ Need refills from MD❒ MD discontinued❒ Difficult dosing schedule Cont. Next Page❒ Don’t understand how to take❒ Don’t want to take it❒ Don’t feel that the medication is working❒ OtherIf other, what is the reason? |  |
| Do you currently use tobacco products?❒ Yes❒ No |  |
| If currently using, would you like to take to someone about quitting tobacco products?❒ Yes❒ No |  |
| Do you currently drink alcoholic beverages?❒ Yes❒ No |  |
| How often do you drink alcoholic beverages?❒ Daily❒ 4 days a week❒ 2-3 days a week❒ 1 day a week❒ None |  |
| Do you feel your use of alcohol is excessive?❒ Yes❒ No |  |
| If currently using alcoholic beverages, would you like to talk to someone about quitting alcoholic beverages?❒ Yes❒ No |  |
| Do you exercise?❒ Yes❒ No |  |
| Describe your interest in increasing the amount of exercise to improve your health:❒ I have no need to❒ I have no plans to❒ I plan to within the next month❒ I plan to within the next six months❒ I plan to within the next year |  |
| Do you meet with a mental health therapist regularly?❒ Yes❒ No |  |
| Do you need assistance with locating a mental health therapist?❒ Yes❒ No |  |
| Abuse/ Neglect Staff Assessment:(Please mark any positive findings)❒ Inadequate Hygiene❒ Signs of physical abuse❒ Restraints❒ Burns❒ Social Isolation❒ Threats of Injury❒ Signs of psychological abuse❒ Dehydrated❒ Malnourished❒ Inadequate Clothing❒ Condition of home is disrepair Cont. next page❒ Not receiving medical care❒ Not receiving or taking medication❒ Financial Issues❒ Difficulty paying utility bills❒ Other (Please List) |  |
| Over the last month, how would you rate your interest in participating in activities of interest to you?❒ All the time❒ More than half the time❒ Half the time❒ Less than half the time❒ Not at all |  |
| Over the last month, how often would you say you felt down, depressed or hopeless?❒ All the time❒ More than half the time❒ Half the time❒ Less than half the time❒ Not at all |  |
| If any positive answers above would the client accept a referral to a behavioral health professional?❒ Yes❒ No |  |
| Have you recently experienced any losses or significant changes in your life?❒ Yes❒ NoIf you have experienced any losses or significant changes in your life, what were they? |  |
| Which of the following best describes your current living situation?❒ Live alone❒ Live with spouse or significant other❒ Live with family member or friend❒ Supervision or assistance by paid help❒ Living in a facility❒ Other (If other, please explain) |  |
| Do you receive or need assistance from others for activities of daily living (Feeding self, Clothing self, Washing self)?❒ No❒ Rarely❒ Weekly❒ Several times a week❒ Daily |  |
| If you do receive assistance for activities of daily living, who provides them?❒ Family Member❒ Friend or Neighbor❒ Paid Help❒ Other |  |
| Is the subscriber wheelchair bound?❒ Yes❒ No |  |
| Is the subscriber bed bound?❒ Yes❒ No |  |
| Are there any safety concerns in the home for any of the following?❒ None❒ Inadequate supply of food in home❒ Structural barriers in home that limit independent mobility.❒ Narrow or obstructed hallways and/or doorways❒ Inadequate floor, roof or windows❒ Unsafe gas or electric appliances❒ Inadequate heating or air conditioning❒ Lack of fire safety devices❒ Home in disarray❒ Other |  |
| Are there any safety concerns in the home for sanitation issues for any of the following?❒ None❒ No running water❒ Contaminated water❒ No toileting facilities❒ Outdoor toileting facilities only❒ Inadequate sewage disposal❒ Inadequate/improper food storage ❒ No food refrigeration❒ No cooking facilities❒ Insect or rodent infestation present❒ No scheduled trash pickup❒ Clustered/soiled living areas❒ Other (Please describe) |  |
| Have you fallen 2 or more times in the last 3 months?❒ Yes❒ No |  |
| Are there any issues identified in the home that could be a fall risk?❒ None❒ CNS Issues (Dizziness, unsteady gait, loss of sensation in feet, etc.)❒ Hearing problems❒ Vision problems❒ Poor footwear❒ Use of assistive devices❒ Takes multiple attempts to rise from chair or bed before successfully getting up❒ Unable to rise from bed or chair without assistance❒ Unsafe floor coverings/ loose rugs, carpets or tiles❒ Stairs used occasionally❒ Stairs railing loose or missing❒ Inadequate lighting❒ Use of alcohol daily |  |