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  ❒ No  If 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  ❒ Other  If 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  ❒ No  If 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 |  |